Clinical Issues in the Assessment of Competency

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The evaluation of a patient's competency to consent to treatment, regardless of the test of competency used, can be substantially affected by a number of clinical factors. The authors point out that, in assessing competency, the clinician must consider 1) psychodynamic elements of the patient's personality, 2) the accuracy of the historical information conveyed by the patient, 3) the accuracy and completeness of the information disclosed to the patient, 4) the stability of the patient's mental status over time, and 5) the effect of the setting in which consent is obtained. Inattention to these factors can lead to errors in assessment of competency that can have important implications for patient care.

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As the doctrine of informed consent has increasingly commanded the attention of medicine in general and of psychiatry in particular (1, 2), there has been a simultaneous growth in interest in elucidating characteristics that render an individual competent to offer informed consent (3, 4). The requirement that consent to treatment be made by a competent person is said to ensure that a number of the policy goals underlying informed consent are actually realized: that the autonomy of the competent patient is recognized and the interests of the incompetent patient are protected by some other means. In addition, the mandate that the wishes of the competent individual be honored fosters respect for the individual (5).

Although competency is a legal concept and all individuals are presumed by the law to be competent until determined otherwise in a judicial hearing, the practical realities of clinical care often require that psychiatrists make their own assessments of whether a patient is competent or not. We might call this a determination of "psychological capacity" rather than "legal competence," but the impact of the psychiatrist's decision is often just as important as that of decisions emanating from the bench. It is the psychiatrist who is often called on to decide if a judicial determination of competency is warranted, because an immediate resort to the courts whenever the question of incompetency arises is too time-consuming and expensive. Further, once the case arrives in court the psychiatrist's assessment often serves as the major source of data for the judge's decision (6).

There are many reasons why psychiatrists, even more than other physicians, are likely to become involved in evaluations of competency. A large number of patients seen in psychiatric settings may suffer from impairment of their capacity to decide about options for treatment, presumably as a result of their mental illness (7 and unpublished 1980 data of Roth and associates). Psychiatric sensitivity to the possibility that a patient may be incompetent to consent to or to refuse treatment is essential in those jurisdictions in which recent laws or judicial decisions have required competent consent before treatment can begin (8–10). Even in jurisdictions that have not yet been directly affected by such rules, however, the evolving structure of malpractice law may leave the clinician liable for harm suffered by the patient as a result of treatment that was not preceded by competent consent (2, 11).

Psychiatrists have another route to involvement with questions of patient competency. As experts in dealing with patients who have problematic mental states (12), psychiatrists are often called on by their medical and surgical colleagues to assess patients in medical settings whose status in regard to competency is in doubt. In these settings the psychiatrist is often looked to for "permission" to proceed with treatment without involving the courts.

Given the importance for the psychiatrist of developing skills for the assessment of competency, it is disappointing that relatively few papers in the psychiatric literature have directly addressed the problem. Some suggestions, however, have begun to emerge for substantive standards to be used in assessing a patient's status (3, 4, 13–17). Our intent in this paper is not to attempt to define the elements of a test of competency but, rather, to address clinical factors that are likely to affect the assessment of competency regardless of which substantive test is used. We will examine five potentially influential factors, illustrating each with a case example (disguised to protect the identity of the patients) that we took from our clinical experience.

PSYCHODYNAMIC FACTORS

The legal model of informed consent seems to anticipate that the average decision maker will attend to the information

that is presented and will then rationally evaluate his or her alternatives on the basis of the medically relevant risks and benefits. Clinicians, however, are aware that decisions are rarely made in such an affective vacuum. The seemingly neutral words of the informed consent form or doctor-patient consent interview can, in fact, be highly charged for the patient. The idiosyncratic meaning for the patient of any suggested procedure is a function of each patient's unique matrix of previous experiences.

If the treatment or procedure for which consent is being sought is sufficiently provocative of anxiety and fear, the patient may be forced to revert to more primitive, even psychotic, levels of defense for coping with it. Thus the recommendation for the procedure itself may force the patient into an apparently incompetent state and may preclude the obtaining of competent consent. The following case demonstrates such a situation.

Case 1

Ms. A, a 74-year-old unmarried retired medical secretary with a history of three acute psychotic episodes, had a residual paranoid delusional system that could be diminished but not eliminated with medication. She lived in a nursing home.

Two weeks before psychiatric consultation was requested, a routine physical examination at the nursing home revealed a large lump in Ms. A's left breast, with retraction of the nipple. A surgical consultant recommended biopsy and probable mastectomy. The surgeon discussed the procedure with the patient and was satisfied that, especially in the light of her familiarity with medical terminology, he had obtained informed consent to the procedure from her. The administrators of the nursing home, however, concerned about their liability, requested that a formal psychiatric assessment of her competency be made and arranged an appointment for the assessment.

When Ms. A arrived at the psychiatric clinic for the evaluation, accompanied by the continuing care nurse who followed her regularly, she disclosed that since meeting with the surgeon she had received a phone call from him saying that she did not need the surgery, that he had recommended it only because his wife needed more money, and that her nephew—her closest relative, who acted as conservator of her funds—wanted her to undergo the procedure so that she would die sooner and he could take her money. A call to the surgeon's office revealed that the alleged phone call had never taken place. Nonetheless, the patient clung to her story and refused the procedure. It was the examiner's opinion that her refusal was based on her delusional beliefs and that it appeared to be incompetent. He and the nurse agreed to explore the possibility of the nephew's acting as guardian to give substituted consent for the procedure.

A repeat surgical examination 2 weeks later showed that the lump was expanding rapidly, that there was danger of ulceration through the skin, and that surgery was urgently needed. The patient's nephew, fed up with her accusations that he was stealing her money, had declined to act as guardian, and the option of approaching the court directly for permission to operate was being investigated. The psychiatrist decided to reevaluate the patient, who had indicated some willingness to proceed with surgery: the reassessment took place one month after the initial assessment.

Although still clinging to her story of the phone call from the surgeon, she now maintained that she was basing her continued refusal of surgery on other grounds: 1) she was afraid of dying during the operation, and 2) she felt that she had led a full life and was willing to take her chances on not removing the apparent cancer, which she recognized could lead to her death. The examiner's impression was that she still was delusional but that her refusal was based on rational reasoning and therefore was probably competent. A clinical conference with a senior clinician and the hospital's attorney was arranged to review the case.

At the conference, the patient discussed her fear of the operation in terms that emphasized her dread of being abandoned by all of her caretakers and left to die. Just as all her acute psychotic episodes had been provoked by interpersonal losses and her paranoid delusions and hallucinations had always seemed to serve a restitutive function, so it appeared that her psychotic response to the recommendation for surgery was an attempt to draw those around her into deeper involvement. When these concerns were pointed out to her and empathized with, she indicated that although she still feared the surgery, she would accept it. It was agreed that the continuing care nurse would continue to visit her often and would accompany her to the surgeon's office, where her formal consent would be obtained.

The biopsy performed after consent was obtained revealed a carcinoma: an extended simple mastectomy was performed. The patient recovered from the surgery without medical complications and without exacerbation of her psychosis.

This woman's fears had been aroused by the peculiar latent meaning that a mastectomy held for her: that it would be a stimulus for those around her to withdraw, leaving her alone with nothing but death ahead of her. As her fears were explored in a setting she could trust, she was able to relinquish her need for psychotic mechanisms of defense, to be reassured that her fear of the results of the surgery was unrealistic, and to provide reasonable consent to a procedure that was manifestly in her best interest.

The interpersonal consequences of the proposed procedure do not represent the only basis for the development of psychotic ideation.

Case 2

Ms. B, a 43-year-old woman diagnosed as schizophrenic, had long-standing bilateral glaucoma. In one eye, vision remained only for motion. Because the intraocular pressure in the other eye, which had better vision, was poorly controlled by medication, the patient's opthalmologist proposed a drainage procedure for that eye.

Although Ms. B was worried about the pressure in her eye and fearful of going blind, she refused the drainage procedure, explaining that her "voices" would be "angry with her"

if she underwent the procedure. When her reasons for refusal were explored further, the patient noted that her mother had had a similar drainage procedure for glaucoma that had not been helpful. The patient then discussed her attachment to her mother, noting in a symbiotic and concrete fashion that she knew that whatever happened to her mother would also happen to her.

The suggestion for glaucoma surgery in this case appeared to provoke a threatening identification with the patient's mother, a merger that the patient's "voices" resisted by commanding the patient to refuse the operation. While the identification of this dynamic was not in itself sufficient to allow the patient to drop this defensive posture, it did clarify the basis for her refusal and confirmed its psychotic and therefore apparently incompetent nature. Failure to explore the basis for the patient's refusal would have left this point in doubt. An assessment of the psychodynamic basis of the patient's refusal should be part of every competency examination.

INFORMATION PROVIDED BY THE PATIENT

In many consultation situations the psychiatrist is called on to examine the patient and to give an opinion, on the basis of that examination alone, whether or not the patient is competent to consent. One obvious difficulty is that in some circumstances in which questions have been raised as to the patient's competency, the patient may be a less than reliable informant of data critical to the assessment.

Case 3

Ms. C, a 51-year-old woman, was committed to the hospital after she threatened to harm her husband. The patient had been falsely accusing her husband of having multiple marital affairs. When initially evaluated at the hospital, the patient looked quite well and denied illness or any impairment in her thinking. It was only when additional data were obtained from her husband and her physician (both of whom had for 2 years had progressive difficulty coping with her delusions and escalating paranoia) that the nature of the patient's problem became more evident. The psychiatrist learned from the patient's husband and physician that the patient had been expressing many delusional beliefs and was acting peculiarly at home. e.g., she had believed that her former physician had been taking her to the woods to have sex with her in the company of other doctors: she now believed that her husband was the father of all her sister's children.

As a rule of thumb, the competency assessment should be considered incomplete unless the patient's history has been authenticated by someone who is familiar with his or her behavior in his or her natural environment. Such a procedure not only confirms the accuracy of the factual data but also serves as a yardstick by which to measure the nature of the patient's appreciation of his or her illness or, conversely, the magnitude of the patient's denial.

INFORMATION PRESENTED TO THE PATIENT

One cannot logically conclude that a patient who manifests insufficient or distorted knowledge of the nature of his or her situation and the proposed remedies does so as the result of deficiencies in mental functioning unless one knows the nature and the scope of the information that was revealed to the patient in the first place. In the modern general hospital, in which many professionals share responsibility for each patient's care, it becomes increasingly likely that no one person will consider it his or her unique duty to sit down with the patient to provide the necessary information. Different staff members might each provide incomplete and confusing information (18). Even if the information had been communicated at some point, the patient might have forgotten it by the time the competency assessment takes place. This leaves the consulting psychiatrist in a position of uncertainty as to whether the locus of the patient's problem is best characterized as in the patient or elsewhere in the hospital.

Case 4

Mr. D, a 37-year-old man, was admitted to the hospital after being struck in the head during a robbery. He sustained a basilar skull fracture, and a CT scan revealed a left frontal epidural bleed. The patient signed a consent form agreeing to craniotomy and evacuation of the left epidural clot. The next day, however, he refused the procedure, indicating that he wanted "a few more days to think it over." He also said that he wished to leave the hospital against medical advice. When discussing the proposed surgery with a psychiatric consultant (who had been asked to evaluate the patient's "competency" to refuse). Mr. D made many offhand comments that were difficult to analyze, e.g., he noted with respect to the consequences of his refusal that. "Of course, everyone dies." It was unclear to the psychiatric consultant whether the confused responses were the result of the inadequacy of the information previously given to the patient about the procedure or whether the patient's indifference to his outcome was the consequence of brain dysfunction and injury. Only when the patient was reinterviewed by his neurosurgeon, who told him slowly and in great detail about the proposed procedure, did it become clear that the patient could not understand. He believed that his previous discussions with the neurosurgeon had been about the subject of "getting a loan."

The psychiatric consultant should insist that an explanation or reexplanation of the relevant material take place in his or her presence. Preferably, this should be done by the physician who is primarily responsible for the patient's care. This not only aids in helping to explain a patient's distortion, lack of understanding, or confusion, but will also help to clarify for the consultant the precise nature of the issues involved, including their urgency. Affective indifference on the part of a patient who is faced with a recommendation for immediate treatment may raise even greater doubts about a patient's competency than would a similar reaction from a patient who has been told that the suggested procedure is partly elective.

STABILITY OF THE PATIENT'S MENTAL STATUS

Competency is not necessarily a fixed state that can be assessed with equivalent results at any one of a number of times. Like the patient's mental status as a whole, a patient's competency may fluctuate as a function of the natural course of his or her illness, response to treatment, psychodynamic factors (see the case of Ms. A), metabolic status, intercurrent illnesses, or the effect of medications.

Case 5

Mr. E, a 55-year-old man, was admitted to the hospital virtually mute and with urinary retention. A thorough medical workup revealed no cause for the patient's condition save depression. At times the patient talked spontaneously about communications from outer space. He was otherwise unresponsive to staff questioning. The staff attempted to explain his illness to him and to solicit his consent for ECT. The patient made no response whatsoever to this information. Because the patient was not eating or drinking, immediate administration of ECT was judged necessary. The patient seemed obviously "incompetent." It was decided that an emergency hearing to evaluate his competency should be scheduled. One day later (before the court hearing could be scheduled), however, the patient began to talk. He indicated that he simply "hadn't felt much like talking over the last few days." He was, at this time, able to give a complete medical history and to discuss comprehendingly the risks, benefits, and alternatives of receiving ECT. Before the treatment could be started, however, Mr. E again became mute.

Case 6

Ms. F, an 18-year-old girl diagnosed as schizophrenic, was admitted to the hospital after a family argument. Her urine test for pregnancy was positive. The staff wanted to discuss the possibility of abortion with the patient but was unsuccessful in doing so. She spent much of her time staring into space and playing with her fingers. She responded to the simplest questions with jargon or irrelevant answers. For example, when asked to give the names of her friends or family, she responded, "1 can't get past my big teeth." Because of her pregnancy, it was decided not to treat the patient with medication but to continue to observe her in the hospital. She improved considerably over the next week. Although her speech remained somewhat tangential, she nevertheless became able to discuss what abortion meant to her and to indicate that she might want to have the baby and then give it to her sister to raise.

Whenever the assessment of competency is being conducted in a nonemergency setting, more than one evaluation session should take place. Had this rule not been followed for Mr. E, Ms. F, and Ms. A, depending on when the evaluation took place, the psychiatrist could have arrived at one of a number of mutually exclusive conclusions: that the patient was offering competent consent, incompetent refusal, or competent refusal or was not sufficiently competent to evidence a choice at all. The magnitude of the intrusion on a patient's autonomy that is represented by the consequences of a finding of incompetency and the impact of allowing a competent patient to refuse potentially life-saving treatment both argue for a cautious approach to evaluation of competency, represented by at least two contacts with the patient on at least two different days.

EFFECT OF THE SETTING

Much as the meaning for the patient of the recommended treatment may affect the patient's response to it, the setting in which the consent is sought and the nature of the person who is seeking it can have similar effects. That a patient is unwilling or unable to attend to a presentation of information from a physician he or she dislikes or in a hospital at which she or he is furious does not warrant the conclusion that the patient is necessarily unable or unwilling to hear the information from another person or in another place.

Case 7

Ms. G, a 26-year-old black woman with juvenile-onset diabetes, was admitted to the hospital with cellulitis of the leg. She had had many previous surgical procedures, including amputation of all her toes and partial amputation of one hand. The patient was extremely angry when admitted to the hospital. She would not talk and refused an intravenous line, antibiotics, and to have her leg dressed. The psychiatric consultation service was called to see the patient to evaluate the nature of her refusal and her "competency to refuse." This was impossible to do because the patient would not talk to the psychiatric consultant, who was white. After being evaluated by a black medical resident, however, the patient became somewhat more cooperative. She began eating and drinking, even though she would not accept other treatment. It was only after meeting and discussing her situation with a black hospital maintenance worker (whom she had known previously) that she became more cooperative and more willing to talk about her need for intravenous antibiotic therapy. She continued to show no interest in psychiatric consultation.

This kind of difficulty is more likely to arise when patient and physician are of different races or of disparate social classes, but whenever there is reason to believe that interpersonal factors are affecting the patient's ability to formulate a competent decision, the assessment should be performed again with the assistance of someone who is more likely to be found congenial by the patient. The same applies, of course, if the patient displays an antipathy for the psychiatrist who is undertaking the competency assessment and refuses to "perform" for him or her.

DISCUSSION

When psychiatrists interact with the legal system, there is always a danger that the clinician will abandon the uncertainties of the clinical perspective for the alluring

rationality of legal thought. As tempting as that may be, we must remember that the presumptions of the law are abstractions that, although useful in the system where they originated, are inexact approximations of the reality that the clinician experiences every day. The legal approach to competency is a case in point. The law has tended to address competency as a fixed attribute of an individual, a characteristic in itself with an inherent stability. The clinician, on the other hand, knows that what the law calls competency is, in fact, a set of deductions from a variety of clinical data that can be as subject to influence and change as the more basic mental attributes on which it is based.

The most serious mistake that a clinician can make in evaluating a patient's competency to consent to treatment is to neglect this knowledge and to pretend that the task is, as the law sometimes seems to envision it, to assess a patient's functioning at a single time, in a single setting, with an uncertain factual base, for the purpose of drawing global conclusions about a patient's functioning. However much easier it may be to work with the more simplistic model, the consequences of the inaccurate determinations that thereby become more likely are too grave to ignore. False positive findings of incompetency will provoke unnecessary court procedures, with attendant delays in the patient's treatment, expense, and time lost for clinical care. In addition, truly competent patients whose decisions are overridden can suffer substantial injury to their sense of self. False negative findings of competency leave patients who have inadequate decisionmaking powers without the protections afforded by substitute decision makers and leave physicians open to potential legal liability.

The need for care in assessment should be evident. Yet clinicians who would be loathe to offer a diagnosis and dynamic formulation for an outpatient after one visit are often surprisingly willing to declare a patient competent or incompetent on the basis of a single brief interaction. Such an approach neglects the clinical verities that patients will often not articulate their most important concerns on the initial visit and that interventions themselves may be part of the diagnostic process. The exploration of dynamic issues has both diagnostic and therapeutic dimensions (as in Ms. A's case). The same is equally true for a maneuver such as a trial of a lower dose of sleeping medication in a confused and apparently incompetent patient.

As in all other kinds of psychiatric consultations, the psychiatrist evaluating competency must continue to think clinically about the issues before him. A finding of probable incompetency on an initial assessment should be seen as the identification of a set of indications that, like any similar findings in medicine or in psychiatry, require a differential diagnostic approach, appropriate investigation, and reassessment of the patient following therapeutic intervention. Although the consulting psychiatrist who is performing the competency assessment is often not in a position to perform the investigation or to begin the therapy, he or she ought at least to call to the attention of the responsible physician the need for further diagnostic studies and possible modes of treatment. In essence, the psychiatrist needs to rule out possible causes of "pseudo-incompetency"—including those discussed above—in order to arrive at the conclusion that, despite repeated efforts to communicate with the patient, the patient cannot understand and very likely is incompetent to consent or to refuse.

The need for a clinical orientation to the competency evaluation should not obscure the fact that in the end the patient's competency is a matter for the courts to decide. Perhaps the most valuable service that psychiatrists can perform for the courts in such cases is to provide a factual basis for the legal determination that corresponds to the patient's clinical state.

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