

## Assessing Civil Competence

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*Many people think psychiatric illness routinely renders patients incompetent to make important decisions about their lives. This month's column, by Dr. Brian Crowley of Washington, DC, attacks that myth and discusses some situations in which clinicians must address their patients' mental capacity.*

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Practicing psychiatrists are not often asked to assess their patients' mental capacity (competence) to perform ordinary contractual tasks, such as selling a house, signing into the hospital, or making decisions about their own medical care, among a host of other functions. We have great respect for our patients' freedom of action and rarely intervene in their decisions. However, when a problem or dispute about the patient's mental competence develops, the issue comes to our attention front and center. Psychiatrists who do forensic work, of course, are often asked to make such evaluations, either in the here and now, or retrospectively. Thus, all psychiatrists need to know the issues involved and be able to deal with them as needed, since any of us may be asked for them on occasion through our careers. In this column, I discuss practical, everyday issues involved in performing assessments of civil competence.

One of the clearest court opinions on the meaning of competency to contract comes from *Davis v. Marshall 1994* (6, Ohio App Lexis 3538, as quoted in Simon and Shuman, pp.30–31):<sup>1</sup>

The test of competency to contract is whether the powers of a person's mind have been so affected as to destroy the ability to understand the nature of the act in which he is engaged, its scope and effect or its nature and consequences.... If a person, at the time of entering into a contract, understands the nature, extent and scope of the business he is about to transact, and possesses that degree of mental strength which would enable him to transact ordinary business, he is in law considered a person of

sound mind and memory.... **Furthermore, a party who has not been adjudicated as mentally incompetent in a court of law is presumed to be competent. However, the presumption of competency is rebuttable.** If the presumption of competency is rebutted, then the contract entered into by the mentally incompetent individual is voidable.... By contrast, a formal adjudication of incompetency and appointment of a guardian divests the individual of any contractual capacity, thus making any contract entered into by the mentally incompetent person void... [*bold added for emphasis*].

Two examples will help illustrate the types of questions that can arise in assessing civil competence. The first involves an acutely disturbed patient who presents to the general hospital's emergency department and then signs into the psychiatric unit, while the second involves assessing contractual competence in an ill elderly person in a residential setting. It should be noted that these examples reflect Maryland law, and that, although similar laws and rules exist in every state, specific provisions will vary from one jurisdiction to another.

### **Example 1. Acutely disturbed patient who signs into the psychiatric unit**

I have long served on the medical staff of Suburban Hospital in Bethesda, Maryland, which runs an excellent, 24-bed, acute general hospital behavioral health unit, which cares for a wide mix of patients with psychiatric and substance abuse diagnoses.

The hospital accepts for admission *only* patients who enter—from the emergency room (ER) or directly from outside the hospital—on the basis of a formal voluntary admission. Maryland law wisely provides, among other things, that a prospective patient must sign a formal voluntary admission agreement. If the patient wishes to

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leave prematurely (against medical advice) during his or her inpatient stay, he or she must give written notice of intent to leave, which triggers a waiting period of up to 72 hours during which time the patient may reconsider and stay (which often occurs); be discharged against medical advice or with medical agreement; or be committed on two physicians' certificates and sent to a hospital legally authorized to accept committed patients. Many important clinical issues are beneficially worked through during this legally-mandated "cooling off" period.

Patients present in the ER with a host of conditions, including paranoid, delusional psychoses, disabling depressions, acute intoxication with alcohol or drugs of abuse, or in massive denial after a frank suicide attempt. The team who perform the evaluation and recommend action take a pragmatic approach. If they believe the patient can be safely referred to an outpatient treatment resource or a partial hospitalization program, this is done. If a patient's blood alcohol needs to fall before a decision is made, the patient is cared for in the ER until that happens; if medical complications require admission to internal medical, trauma, or surgery services, transfer to those services is arranged. Patients who are deemed not able to leave the hospital because of inability to function outside or danger to self or others are offered admission to our unit—unless the problem exceeds our service's capacity, in which case admission to a specialized hospital bed is sought. (In one vivid example, which I will never forget, a young man came into the ER carrying the hammer with which he had just beaten his mother to death. He was transferred from the ER to the state maximum security forensic hospital.)

When a patient is offered admission to the psychiatric unit, the patient's signature may be accepted on the sign-in form despite the presence of psychosis, ambivalence, partial dementia, or other conditions that could clearly call into question the individual's full mental competence to enter into a valid contract. We accept patients' signatures in this situation because the alternatives may well be either allowing the patient to go without care or civil commitment to another hospital. If a patient is delusional and dangerous, or psychotically depressed and suicidal, our staff urges the patient to sign in voluntarily since hospitalization would be in the patient's best interests; the staff may tell the patient that if he or she declines and our professional assessment reflects that the patient is a clear danger to self or others, we may have to institute a commitment procedure for the patient's safety and that of others. We try to make sure the patient understands the evaluation and

the options as well as he or she can. The assistance of relatives may also be sought. Nevertheless, despite the patient's impairments, we will usually accept his or her signature as a formal voluntary admission.

If questioned about the practice of allowing obviously impaired mental patients to sign in, I refer to the legal presumption of competence as well as criteria for competence to consent to hospitalization (see below). Thus, we accept the patient's signature even when we understand that the patient's competence may be impaired, for two reasons: 1) voluntary admission is deemed in the patient's best interest, and 2) the patient is presumed competent as a matter of law unless adjudicated otherwise. As often happens, the clinically best course of action also happens to be both legally and ethically sound. Put another way: practicing good clinical medicine, with full awareness of the relevant legal and ethical principles, remains the best course of action for all parties concerned.

A related concept is the patient's *competence to consent to hospitalization or treatment*, and it is also correct to view the distressed patient's decision to sign in to the hospital (or not) in that related framework. As Appelbaum and Gutheil<sup>2</sup> wrote (p. 158):

Informed consent need not be obtained in emergency situations. The key to this exception, of course, is how an emergency is defined.... Genuine emergencies do, of course, exist in psychiatry. A violent, excited, or self-mutilating psychotic patient in the emergency room or on the inpatient ward may require immediate restraint or medication, or both, to prevent physical harm to self or others.

Since hospitalization is a relatively safe event, with comparatively little risk to the person, whereas refusing hospitalization in these circumstances is a relatively dangerous event, the criteria for competence to consent to hospitalization are less restrictive than the criteria for refusal thereof. (William Reid, MD, MPH, personal communication, October 2006). The author's view is that offering the disturbed patient in the ER the option of voluntary admission is frequently the best course of action, clinically and ethically as well as legally.

Familiarity with the legal principles which undergird the practice of psychiatry is essential in making good clinical and administrative decisions. It is not rare that, after half a day on the psychiatric unit, our newly admitted patient decides that he or she does not belong there and demands to leave: "These other people are disturbed. I don't belong in this place!" In this situation,

the staff refer to the law, which mandates that the patient must give 72 hours' notice of intent to leave against medical advice. The patient may then say, "No, I'm leaving now" or "You didn't tell me," or "I was misled," or "I don't agree." The staff then say, "We are sorry, Mr. A, but you have to stay. That provision of the law is a time-honored structure that is there to give you, and your doctor, an opportunity to consider the alternatives together, for the protection of yourself and others."

The next day, the patient is most often happy to be in the treatment program on the unit and pleased to stay and to rescind the 72-hour notice, if in fact one has been signed.

## **Example 2: A dispute over a contractual decision taken late in life**

When a dispute arises over a will, a psychiatrist may be asked for an opinion on whether the maker (the testator) did or did not possess testamentary capacity, defined as competence to make a will. To make a valid will, a person must possess three elements of mental capacity, all cognitive in nature. The person must:

- Know that he or she is making a will and what that means;
- Know the rough extent of his or her estate;
- Know "the natural objects of his or her bounty." These are the close relatives a person would normally consider in disposing of his or her property.

Contractual capacity in general is not as precisely defined as testamentary capacity. "Statutes and court decisions have done little to move beyond the vaguest description of general competence" (p. 221).<sup>2</sup> "Usually individuals are considered competent to contract if they understand the nature of the contract and its consequences" (p. 216).<sup>3</sup> To make a valid contract, a person must know what he or she is doing, its meaning, and its consequences.

Most clinical notes, unfortunately, contain no clue as to whether the testator had any or all of those three elements of testamentary capacity. And those three elements of mental status, all cognitive in nature, are all that matter when a will later comes under legal assault as possibly incompetent. Legal cases have held that even when substantial mental impairment may exist, the testator in "a lucid interval" may be able to make a valid will. The law in its deliberate majesty respects, and will not lightly overturn, a person's final contracts and wills.

Consider the following actual example of a contract that later came to be disputed in litigation.

*Four years ago, Emma Jones, an 86-year-old resident of a nursing home, decided to sell (essentially give) her home to a male companion, Mr. Jackson, for one dollar. She then passed away. Subsequently, Mr. Jackson sold the home at market value to a young couple. Now trouble has arisen. The estate of Ms. Jones (two distant relatives) sued, claiming the home should revert to the estate, alleging that Ms. Jones was mentally incompetent to contract to sell the home to Mr. Jackson, as she was suffering from Alzheimer's disease. If this action succeeds, the young couple who purchased the house will be out of house and home, or at least in a financial bind, since the title insurance would cover the value of the home at the time of the sale, but not the considerable appreciation that has occurred since that time.*

I was asked by the young couple's attorney (who also represents the title insurance company) to perform a retrospective review of the claim that Ms. Jones lacked contractual capacity when she deeded her home to Mr. Jackson. Such retrospective reviews of someone's mental state at a time in the past are frequently requested in forensic psychiatry. For example, one may be asked to evaluate whether a woman was competent to make a will when she left all her money to charity rather than her relatives and then died. Or a psychiatrist may be asked to assess whether a man was mentally competent and responsible when he allegedly committed a murder 2 years ago? There are forensic procedures for recreating a credible picture of an individual's past state of mind: essentially, we diligently assemble all available data and then make a statement as to what may, and may not, be said with medical certainty on the question. *Retrospective Assessments of Mental States in Litigation: Predicting the Past*, by Robert I. Simon, MD, and Daniel W. Shuman, JD, published in 2002, is a very useful resource in making such assessments.

Practicing psychiatrists should more often record observations in the chart concerning their patients' mental capacities or impairments, which can provide helpful data for a review of competency to contract. It is remarkable how rarely good clinical notes—medical, psychiatric, and neurological—provide data on which such a judgment can be based. How often do we see either of the following two types of notes?

*Ms. Jones, who is 86 years old and suffering partial dementia from Alzheimer's disease, still clearly has full awareness and appreciation of her action today in deeding her home—which she knows is valued at*

*approximately a half million dollars—to Mr. Jackson, her kind companion of the past couple of years. She says emphatically to us today that she would rather give her house to this helpful gentleman, with whom she has shared loving moments, than leave it to distant relatives who never contact her and with whom she shares no positive feelings.*

OR

*Ms. Jones, 86 years old and with Alzheimer's disease, has been slipping lately, with declining memory, somewhat impaired orientation, and vagueness about the value of her home and other possessions. The staff and I are concerned that a Mr. Jackson, who has been coming to see her lately, may be exerting undue influence on her, and might take improper advantage of her failing mental state. Therefore, when she said yesterday that she might give her house to him, as her attending physician I have requested a forensic psychiatry consultation to determine whether she currently possesses the mental capacity to do so competently and of her own free choice.*

One will look through many an otherwise fine clinical record without seeing any entry even vaguely approaching the helpfulness of these two notes.

In the present case, the medical records were available from a neurological practice and from a primary care doctor both of whom had followed Ms. Jones for several years. However, the records stopped a year and a half before Ms. Jones deeded her home to Mr. Jackson. The records showed a diagnosis of Alzheimer's disease, rated as mild to moderate. Entries bearing on the cru-

cial question of competence to contract were few and far between. Although the Mini-Mental State Exam<sup>5</sup> scores that had been recorded ended 18 months before the date in question, they had, interestingly and unexpectedly, risen over time! There was little lay, eyewitness, or relative testimony that could shed light on Ms. Jones' capacity or lack thereof.

After reviewing the records, I told the attorney that, while Ms. Jones might have become incompetent by the time she gave her home to Mr. Jackson, there was no evidence to that effect. Therefore, in my opinion, the presumption of competency was intact and un rebutted. All opposing counsel had was a psychologist who was prepared to testify that, as a general matter, patients with Alzheimer's disease suffer declining mental capacity over time. Thus my retaining attorney, who wished to preserve the sale as a matter of law, was in the far stronger position to prevail in the court case.

## References

1. Simon RI. A clinical review. In: Simon RI, Shuman DW. Retrospective assessment of mental states in litigation: Predicting the past. Arlington, VA: American Psychiatric Publishing; 2002:30–1.
2. Gutheil TS, Appelbaum PS. Clinical handbook of psychiatry and the law, 3rd edition. Baltimore: Lippincott Williams & Wilkins; 2000.
3. Slovenko RJ. Civil competency. In: Simon RI, Gold LH, eds. The American Psychiatric Publishing textbook of forensic psychiatry: The clinician's guide. Arlington, VA: American Psychiatric Publishing; 2004:205–24.
4. Simon RI, Shuman DW. Retrospective assessments of mental states in litigation: Predicting the past. Arlington, VA: American Psychiatric Publishing; 2002.
5. Folstein MF, Folstein SE, McHugh PR. "Mini-Mental State": A practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res 1975;12:189–98.