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# The Empire of Illness: Competence and Coercion in Health-Care Decision Making

Marsha Garrison

# THE EMPIRE OF ILLNESS: COMPETENCE AND COERCION IN HEALTH-CARE DECISION MAKING

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*Abstract*

*The law's willingness to take account of factors that interfere with volition tends to vary in accordance with its underlying goals. The law of wills is dominated by the principle of freedom of testation; it has thus developed doctrines aimed at detecting coercive influences that interfere with the testator's free agency. The law of medical decision making, dominated by the analogous principle of patient autonomy, has not developed doctrines aimed at detecting coercive influences despite a large and growing body of evidence showing that disordered insight and major depression, two common medical conditions, often have a coercive, negative effect on treatment choice and compliance. When a patient is afflicted with disordered insight or major depression, a decision against treatment often stems from illness instead of the patient's own goals and values.*

*Current law fails to protect vulnerable patients whose free agency has been lost to their illnesses. These patients need, and deserve, protection from the coercive effects of distorted perception and motivation. The undue-influence and insane-delusion doctrines developed within the law of wills to detect and disarm coercive influences are readily adaptable to the medical decision-making context. There is a wealth of assessment protocols that offer reliable methods of detecting the influence of depression and insight deficiencies.*

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*This Article advocates a new approach to patient decision making, modeled on the law of wills, that assesses voluntariness as well as competence. This approach is consistent with empirical evidence about the realities of patient decision making and traditional accounts of responsibility and moral culpability. It provides patients with protection against harmful, nonautonomous choices that current law does not.*

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> *I find no false apprehensions, to work upon mine understanding; and yet ... insensibly the* disease *prevailes. The* disease *hath established a* Kingdome, *an* Empire *in mee, and will have certaine ...* secrets of State, *by which it will proceed, and not be bound to* declare *them.*[1]

The law enforces important choices made by the decision maker with liberty and capacity, and it holds her responsible for those choices.[2] But when a decision maker lacks liberty or capacity, the law typically takes a protective stance. This protective policy is evident throughout our legal system: it supports rules that void the contract of a minor, the will of a testator subject to undue influence, and a marriage entered under duress; it underlies civil commitment statutes, the juvenile justice system, and the insanity defense.

Although the concepts of liberty and capacity pervade our legal system, we do not have a uniform definition of either concept. Thus courts have found that the testator's will was void but his marriage valid,[3] and that he was civilly liable but not criminally responsible.[4] Such variation reflects divergence in the goals that underlie different areas of law; the law's interest in concepts like freedom and responsibility "is an interest in *enough* freedom and responsibility to satisfy the purposes and interests at hand."[5] Variation also reflects the fact that both coercion and incapacity describe a broad

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1. John Donne, *Devotions upon Emergent Occasions*, *in* THE COMPLETE POETRY AND SELECTED PROSE OF JOHN DONNE 421, 435 (Charles M. Coffin ed., The Modern Library 1952) (1623).

2. *See* Morissette v. United States, 342 U.S. 246, 250–51 (1952) ("The contention that an injury can amount to a crime only when inflicted by intention is no provincial or transient notion. It is as universal and persistent in mature systems of law as belief in freedom of the human will and a consequent ability and duty of the normal individual to choose between good and evil." (footnote omitted)); *see also* H.L.A. HART, PUNISHMENT AND RESPONSIBILITY: ESSAYS IN THE PHILOSOPHY OF LAW 218 (1968) ("[T]he law of most countries requires that the person liable to be punished should at the time of his crime have had the capacity to understand what he is required by the law to do or not to do, to deliberate and to decide what to do, and to control his conduct in the light of such decisions.... [P]ossession of these [prerequisites] is very often signified by the expression 'responsible for his actions.'").

3. *See, e.g.*, Hoffman v. Kohns, 385 So. 2d 1064, 1069 (Fla. Dist. Ct. App. 1980); Park v. Park, [1954] P. 112, 113 (U.K.).

4. *See, e.g.*, Polmatier v. Russ, 537 A.2d 468, 469, 471 (Conn. 1988); Williams v. Kearbey, 775 P.2d 670, 671 (Kan. Ct. App. 1989). *See generally* 57 C.J.S. *Mental Health* § 224 (1992).

5. SUSAN WOLF, FREEDOM WITHIN REASON 143 (1990); *see also infra* Part I.B.

range of conditions rather than one unvarying state: both the prisoner and the con artist's victim might say that their actions were coerced; the unconscious adult and the normal six-year-old both lack decision-making capacity. Nor are liberty and capacity necessarily gained, or lost, in one fell swoop. The child progresses incrementally in her ability to make informed choices, and many conditions that ultimately destroy liberty or capacity develop slowly, even insidiously. The victim of dementia, for example, typically succumbs to her illness in uneven fits and starts that may extend over decades.[6]

Although health-care professionals typically diagnose impairment and make initial competence determinations, courts ultimately determine whether a particular individual has enough liberty and capacity to make the decision in question. In making this determination, courts must place choices that reflect varying levels and types of impairment into one of two categories: either a decision is competent and voluntary, or it is not.[7]

Capacity and coercion determinations present challenges in all areas of law, but nowhere are these challenges more pressing than in the field of medical decision making. Individuals with serious decisional impairments do not necessarily attempt to execute a will or make a contract, but the fact of serious impairment will typically ensure the need for health-care choices. These choices may determine the individual's state of health and even his survival. They may hinder or advance the medical profession's capacity to test new treatments for conditions like dementia and mental illness. They may entail serious consequences for both the individual's family and the public.

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6. *See* Jane Gross, *Living with Alzheimer's Before a Window Closes*, N.Y. TIMES, Mar. 29, 2007, at A1 (describing various Alzheimer's victims).

7. *See* Scott Y.H. Kim, *When Does Decisional Impairment Become Decisional Incompetence? Ethical and Methodological Issues in Capacity Research in Schizophrenia*, 32 SCHIZOPHRENIA BULL. 92, 93 (2006) (describing clinical difficulties in translating capacity judgments into competence determinations); *cf.* Elyn R. Saks, *Competency To Decide on Treatment and Research: The MacArthur Capacity Instruments*, *in* 2 NAT'L BIOETHICS ADVISORY COMM'N, RESEARCH INVOLVING PERSONS WITH MENTAL DISORDERS THAT MAY AFFECT DECISION MAKING CAPACITY 59, 69 (1999), *available at* http://bioethics.georgetown.edu/nbac/capacity/volumeii.pdf ("Competency standards are the mechanism by which we draw the line between those who will be permitted to exercise their autonomy and those who will be treated paternalistically.").

The current law of medical decision making is ill-equipped to meet these challenges. When deciding whether to enforce a medical decision, courts and legislatures have traditionally utilized a parsimonious approach that looks exclusively at the actor's capacity, or competence, to make the decision in question; in contrast to the law of wills and contracts, subjective factors that might undermine the voluntariness of the actor's choice are not taken into account.[8] When the patient accepts beneficial treatment, this parsimonious approach is warranted; there is no obvious harm when we allow a patient, autonomous or not, to make a decision that comports with her medical interests. However, in recent years evidence has mounted that various common mental conditions often have a coercive effect that may *inhibit* the choice of a beneficial treatment. The parsimonious approach precludes consideration of these conditions and their impact on the patient's choice.

The parsimonious approach is typically justified on the basis of patient autonomy, a guiding principle in the law of medical decision making.[9] Patient autonomy undeniably is—and should be—an important value in medical decision making. But the concept of autonomy that underlies the parsimonious approach is cramped and artificial: it is inconsistent with empirical evidence about the realities of patient decision making;[10] it is inconsistent with traditional accounts of responsibility and moral culpability;[11] and it is inconsistent with principles utilized in analogous areas of law such as wills and contracts.[12]

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8. Courts have awarded patients damages for unauthorized medical treatment and for medical decisions induced by the physician's failure to disclose significant risks inherent in a proposed treatment and that produce the undisclosed risk. *See* sources cited *infra* notes 68-71.

9. *See* MARSHA GARRISON & CARL E. SCHNEIDER, THE LAW OF BIOETHICS: INDIVIDUAL AUTONOMY AND SOCIAL REGULATION 14-15, 1091-93 (2003); CARL E. SCHNEIDER, THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS 3-9 (1998).

10. *See, e.g.*, Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence To Make Medical Decisions*, 48 RUTGERS L. REV. 345, 377 (1996) (concluding that "the right to make decisions for oneself should not be burdened more than is absolutely necessary"); Loren H. Roth et al., *Tests of Competency To Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 280 (1977) (concluding that a competence test requiring only that the patient demonstrate "a preference for or against treatment" is "the most respectful of the autonomy of patient decision making").

11. *See generally* HART, *supra* note 2, at 90-105; MICHAEL MOORE, PLACING BLAME (1997).

12. *See infra* Part I.B; *see also* Leo Katz, *Choice, Consent, and Cycling: The Hidden*

Despite mounting evidence of its deficiencies, the parsimonious model continues to dominate the law of medical decision making and its development. Medical researchers now take this approach to patient consent as a given,[13] and new, standardized patient-assessment tools have been based on it.[14] Although there has been some movement away from the parsimonious model in a couple of isolated contexts, these developments have not had any impact on the broader law of medical decision making.[15]

In this Article, I argue that the law of medical decision making should move beyond the parsimonious model by developing voluntariness doctrines analogous to those employed in the law of wills, and I outline principles to guide development of such doctrines. Part I describes the law of medical decision making; it also compares and contrasts this body of law with the standards governing decision enforceability in other areas. Part II explains why the current law of medical decision making is inadequate to ensure patient autonomy and protect the interests of nonautonomous patients. Part III offers a new approach that is consistent with analogous areas of law and that reflects the research evidence on patient decision making.

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*Limitations of Consent*, 104 MICH. L. REV. 627, 628 (2006) ("Consent does not count if coercion or deception is involved ....").

13. *See, e.g.*, Ruth Cairns et al., *Prevalence and Predictors of Mental Incapacity in Psychiatric In-Patients*, 187 BRIT. J. PSYCHIATRY 379, 379 (2005); Dilip V. Jeste et al., *Magnitude of Impairment in Decisional Capacity in People with Schizophrenia Compared to Normal Subjects: An Overview*, 32 SCHIZOPHRENIA BULL. 121, 121 (2006); Barton Palmer et al., *Assessment of Capacity To Consent to Research Among Older Persons with Schizophrenia, Alzheimer Disease, or Diabetes Mellitus: Comparison of a 3-Item Questionnaire with a Comprehensive Standardized Capacity Instrument*, 62 ARCHIVES GEN. PSYCHIATRY 726, 726 (2005); Luis H. Zayas et al., *Capacity-to-Consent in Psychiatric Research: Development and Preliminary Testing of a Screening Tool*, 15 RES. SOC. WORK PRAC. 545, 545 (2005).

14. *See, e.g.*, Laura B. Dunn et al., *Assessing Decisional Capacity for Clinical Research or Treatment: A Review of Instruments*, 163 AM. J. PSYCHIATRY 1323, 1323 (2006) (reviewing and evaluating twenty-three decisional-capacity assessment instruments and reporting that six instruments tested only understanding of disclosed information, and that eleven tested understanding, appreciation, reasoning, and expression of a choice). *See generally* PAUL S. APPELBAUM & THOMAS GRISSO, MACARTHUR COMPETENCE ASSESSMENT TOOL FOR CLINICAL RESEARCH (MACCAT-CR) (2001); THOMAS GRISSO & PAUL S. APPELBAUM, MACARTHUR COMPETENCE ASSESSMENT TOOL FOR TREATMENT (MACCAT-T) (1998).

15. *See infra* Part I.C.

## I. COMPETENCE AND COERCION: TRADITIONAL LEGAL STANDARDS

### *A. Competence To Consent: The Law's Consistent Emphasis on Cognition*

#### *1. The Law of Medical Decision Making*

Mrs. Rosaria Candura, a seventy-seven-year-old widow with advanced diabetes, was suffering from gangrene in her right foot and leg. Her doctors recommended amputation. After vacillation, Mrs. Candura refused to consent to the operation, and her daughter filed a guardianship petition seeking authority to consent on her mother's behalf. The trial court granted the daughter's petition, but the appellate court reversed.[16]

Reviewing the evidence, the appellate court noted that Mrs. Candura

> has discussed ... the reasons for her decision: that she has been unhappy since the death of her husband; that she does not wish to be a burden to her children; that she does not believe that the operation will cure her; that she does not wish to live as an invalid or in a nursing home; and that she does not fear death but welcomes it. She is discouraged by the failure of the earlier operations to arrest the advance of the gangrene.[17]

The court found that Mrs. Candura was "lucid on some matters and confused on others."[18] More specifically, it concluded that "[h]er train of thought sometimes wanders. Her conception of time is distorted. She is hostile to certain doctors. She is on occasion defensive and sometimes combative in her responses to questioning."[19] Based on this evidence of confusion and distorted thinking, one of two psychiatrists who testified in the trial court found Mrs. Candura incompetent to make a decision about the proposed operation.[20]

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16. Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978).
17. *Id.* at 1234.
18. *Id.*
19. *Id.* at 1234-35.
20. *Id.* at 1235.

The appellate court nonetheless determined that Mrs. Candura was competent to refuse treatment. In its view, the psychiatrist who found Mrs. Candura incompetent had not established that she was "incompeten[t] in the legal sense, but rather that her ability to make a rational choice (by which he means the *medically* rational choice) is impaired by the confusion existing in her mind by virtue of her consideration of irrational and emotional factors."[21] The appellate court concluded that Mrs. Candura was competent "in the legal sense" despite her confusion, because she "made it clear that she does not wish to have the operation even though that decision will in all likelihood lead shortly to her death," and there was "no indication in any of the testimony that [Mrs. Candura's decision was not made] ... with full appreciation of the consequences."[22]

The *Candura* opinion is representative of the traditional approach to competence in the law of medical decision making. Although medical competence statutes vary in their details and emphasis,[23] commentators reviewing the standards have found that competence tests invariably involve one or more of the following elements:

1) ability to communicate a choice;
2) ability to understand the relevant information;
3) ability to appreciate the nature of the situation and its likely consequences; and
4) ability to manipulate information rationally.[24]

What these varied tests share is an exclusive focus on cognitive capacity. A patient may be confused, combative, depressed, or

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21. *Id.*

22. *Id.*

23. Although these statutes exhibit similar themes, their language and emphasis vary considerably. For example, in Idaho a person is competent to make a health-care decision if he is "of ordinary intelligence and awareness sufficient for him or her generally to comprehend the need for, the nature of and the significant risks ordinarily inherent in" the care, IDAHO CODE ANN. § 39-4503 (2007), while in Oregon he need show only the "ability to make and communicate health care decisions to health care providers." OR. REV. STAT. § 127.505(13) (2007).

24. Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities To Consent to Treatment*, 319 NEW ENG. J. MED. 1635, 1635-36 (1988). Many legislative definitions of competence are sufficiently vague that judges have discretion to decide what elements to use in determining the competence of specific patients. Those who have reviewed the results of judicial discretion report that opinions "rarely document which test was used, or what factors about the patient led to the patient's passing or failing the test." Kevin R. Wolff, *Determining Patient Competency in Treatment Refusal Cases*, 24 GA. L. REV. 733, 744 (1990).

despairing. But if she can accurately describe the treatment choice, its corollary risks, and its potential benefits to her, she is competent to consent under all existing standards.[25]

Using the cognitive approach, courts discount or ignore evidence that the patient's decision was influenced by his mental state. Thus, in *In re Quackenbush*,[26] the court discounted expert testimony that the patient, a seventy-two-year-old recluse who had shunned medical care for forty years, was suffering from "an organic brain syndrome with psychotic elements"[27] because another expert testified that the patient "has the mental capacity ... to understand the risks involved if he consents to [or refuses] the operation,"[28] and the patient "seemed reasonably alert"[29] and answered questions responsively during a visit of "about ten minutes" duration.[30] Similarly, in *McKay v. Bergstadt*,[31] the court concluded that a quadriplegic patient "despair[ing] over the prospect of life without the attentive care, companionship and love of his devoted father"[32] and "preoccupied with fear over the quality of his life after [his father's expected] ... death"[33] was competent to forgo life-sustaining respirator care because "he understood that the removal of his life support system would shortly prove fatal."[34] And in *Bouvia v. Superior Court*,[35] the appellate court did not even bother to note the hospital's claim that the patient whose father and husband had both

25. Thus, in *State Department of Human Services v. Northern*, 563 S.W.2d 197, 209 (Tenn. Ct. App. 1978), another case involving a limb amputation, the court opined that capacity "means mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts." Because the seventy-two-year-old patient believed that her feet—"shriveled, rotting and stinking"—would heal without surgery, the court found her "incapable of recognizing facts which would be obvious to a person of normal perception," and thus incompetent. *Id.* at 209-10.

26. 383 A.2d 785, 788 (N.J. Super. Ct. 1978).

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. 801 P.2d 617 (Nev. 1990).

32. *Id.* at 620.

33. *Id.* at 624.

34. *Id.* at 620; *see also* State v. McAfee, 385 S.E.2d 651 (Ga. 1989) (involving a ventilator-dependent quadriplegic, in which the State concluded there was no basis for opposing McAfee's right to refuse treatment).

35. 225 Cal. Rptr. 297 (Ct. App. 1986).

abandoned her was affected by severe depression:[36] "If a right exists," the court opined, "it matters not what 'motivates' its exercise. We find nothing in the law to suggest the right to refuse medical treatment may be exercised only if the patient's *motives* meet someone else's approval."[37]

Although the law of medical decision making is clear, there is considerable evidence that medical personnel who make initial competence determinations do not always follow its dictates. Consider this case study, the subject of a recent survey of British emergency-room physicians:

> A 19 year old woman attends the accident and emergency department. She claims to have taken approximately 20 paracetamol tablets and some 30 amitriptyline tablets about an hour previously. The recommendations of the local poisons centre is for immediate gastric lavage and charcoal therapy.
>
> The woman has been brought in by a friend. She has not vomited. She has no history of deliberate self harm, is not intoxicated, and is fully alert. She states that her friend convinced her to come and that she still wishes to die.
>
> She expressly refuses any form of investigation or treatment despite requests from medical and nursing staff as well as her friend. No other family members are available.[38]

Over 40 percent of surveyed physicians stated that they would "forcibly detain" this patient even if a consulting psychiatrist concluded that she was "mentally competent."[39] The researchers disapprovingly exhorted doctors that they simply must learn the law:

> A competent adult patient has the right to withhold consent to examination, investigation, or treatment even if such a decision is likely to result in death. This right to self determination takes

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36. *See* GARRISON & SCHNEIDER, *supra* note 9, at 261.

37. *Bouvia*, 225 Cal. Rptr. at 306; *see also* Thor v. Super. Ct., 855 P.2d 375 (Cal. 1993).

38. T.B. Hassan et al., *Managing Patients with Deliberate Self Harm Who Refuse Treatment in the Accident and Emergency Department*, 319 BRIT. MED. J. 107, 107 (1999). This case is not purely hypothetical; 58 percent of British emergency-room physicians who responded to this fact pattern reported that they had faced from one to ten similar cases in the previous six months. *Id.* at 108.

39. *Id.*

> priority in law over the duty of care that the doctor feels obliged to practise. It is essential, therefore, that doctors are able to assess capacity using established criteria ....[40]

The researchers added, correctly, that doctors who fail to follow legal requirements are at risk of legal liability.[41]

In sum, although doctors do not always follow the law's dictates, both legal and medical experts agree that patient competence is the sole criterion for patient choice. They also agree that competence should be determined based solely on the patient's cognitive abilities; even the suicidal patient may choose to forgo life-saving medical care if she can accurately describe the treatment choice, its corollary risks, and its potential benefits.

*2. Competence Determination in Other Areas of Law*

The cognitive approach to competence that is employed in the law of medical decision making is fully consistent with the law governing competence determination in other contexts. For example, to make a will, the testator need only have the ability to know:

1) the nature and extent of his property,
2) the persons who are the natural objects of his bounty,
3) the disposition that he is making, and
4) how these elements relate so as to form an orderly plan for the disposition of his property.[42]

Thus, in the case of *In re Wright Estate*,[43] although the testator was frequently drunk, lived in a shack filled with dirt and junk, picked up garbage and hid it in his house, falsely claimed to own a number of houses, insisted on buying furniture that was not for sale, offered kerosene-soaked fish to eat, and failed to speak to his granddaughter in the street, the court nonetheless found him competent to make a will:

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40. *Id.* (footnotes omitted).

41. *See infra* notes 68-71 and accompanying text.

42. JESSE DUKEMINIER & STANLEY M. JOHANSON, WILLS, TRUSTS, AND ESTATES 163 (6th ed. 2000).

43. 60 P.2d 434 (Cal. 1936).

> Testamentary capacity cannot be destroyed by showing a few isolated acts, foibles, idiosyncrasies, moral or mental irregularities or departures from the normal unless they directly bear upon and have influenced the testamentary act.... There is no evidence that he did not appreciate his relations and obligations to others, or that he was not mindful of the property which he possessed.[44]

An individual may have testamentary capacity even if a guardian or conservator has been appointed for him.[45] An otherwise incompetent individual may execute a valid will if he does so during a lucid interval.[46]

Other areas of law apply similar principles. In evaluating the capacity to marry, "courts generally have limited themselves to inquiring whether, at the time of the marriage, the intending spouses were capable of understanding the nature of the act."[47] Capacity to make a contract requires more than a lucid interval, but it similarly rests on an understanding of the nature of the transaction.[48] Throughout the law, competence is determined cognitively, just as it was in *Candura*;[49] in each case, competence is assessed without regard to confusion, brain injury, mental illness, or emotional state.

### *B. Voluntariness: The Law's Inconsistent Efforts To Protect Against Coercive Influences*

In contrast to the law of medical decision making, the law of wills and contracts does not stop at capacity in determining whether a decision is binding. Instead, these areas of law consider a range of factors in an effort to detect decisions that are competent, but nonetheless nonautonomous due to some form of coercion. Thus the bride-to-be who is presented with a premarital contract on the eve of the wedding[50] and the testator whose bequest was induced by

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44. *Id.* at 438; *accord In re* Estate of Stitt, 380 P.2d 601 (Ariz. 1963).

45. *See* THOMAS E. ATKINSON, HANDBOOK OF THE LAW OF WILLS 232 (2d ed. 1953).

46. *See, e.g.*, *Stitt*, 380 P.2d at 601; *In re* Estate of Gentry, 573 P.2d 322 (Or. Ct. App. 1978); *In re* Estate of Sorenson, 274 N.W.2d 694 (Wis. 1979).

47. HARRY D. KRAUSE, FAMILY LAW IN A NUTSHELL 46 (2d ed. 1986).

48. *See* E. ALLEN FARNSWORTH, FARNSWORTH ON CONTRACTS 456-58 (3d ed. 2004).

49. Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978).

50. *See* J. THOMAS OLDHAM, DIVORCE, SEPARATION AND THE DISTRIBUTION OF PROPERTY

misrepresentation[51] may both avoid the consequences of their choices if the court finds that these choices were involuntary.

The law of wills, which is almost exclusively concerned with effectuating the testator's intentions, has developed the most expansive doctrines aimed at ferreting out coercive influences that overcome the decision maker's capacity to make an authentic, autonomous choice. One such doctrine voids bequests that result from "undue influence." An influence is undue when it "overcomes the free agency of the testator, substituting the perpetrator's volition for that of the testator's."[52] If the testator is susceptible to such an influence and an individual with opportunity exerts influence that overpowers the testator's will and determines either a specific bequest or a dispositional plan, all portions of the will infected by the coercive influence are treated as void.[53] Another such doctrine voids bequests resulting from an "insane delusion," that is, a false conception of reality,[54] for example, a belief—against the evidence—that the testator's wife is unfaithful,[55] that his children are plotting against him,[56] or that all men are "vicious and contemptible."[57]

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§ 4.03[2][d] (1989) (summarizing cases).

51. Fraud in the inducement refers to the misrepresentation of facts, for example, whether a proposed beneficiary is alive. Fraud in the execution refers to a misrepresentation of the character or contents of the instrument signed by the testator. Most courts require a finding that the misrepresentation was made with the intent to deceive the testator and for the purpose of influencing the testamentary disposition as a precondition to striking down the tainted disposition. *See* DUKEMINIER & JOHANSON, *supra* note 42, at 213-15.

52. LAWRENCE W. WAGGONER ET AL., FAMILY PROPERTY LAW 221 (1991); *see also* RESTATEMENT (THIRD) OF PROP.: WILLS AND OTHER DONATIVE TRANSFERS § 8.3(b) (2003) (noting that undue influence occurs when a "wrongdoer exerted such influence over the [testator] that it overcame the [testator's] free will and caused the [testator] to make a donative transfer that the [testator] would not otherwise have made").

53. The burden of establishing undue influence is on the will contestant, who must show that "(1) the [testator] was susceptible to undue influence, (2) the alleged [influencer] had opportunity to exert undue influence [upon the testator], (3) the alleged [influencer] had a disposition to exert undue influence, and (4) [the will] appear[ed] to be the effect of the undue influence." RESTATEMENT (THIRD) OF PROP., *supra* note 52, at § 8.1(b) cmt. e; *see also In re* Estate of Kamesar, 259 N.W.2d 733, 737-38 (Wis. 1977); DUKEMINIER & JOHANSON, *supra* note 42, at 143-44.

54. *See* DUKEMINIER & JOHANSON, *supra* note 42, at 165-66.

55. *See In re* Honigman's Will, 168 N.E.2d 676 (N.Y. 1960).

56. *See In re* Estate of Raney, 799 P.2d 986 (Kan. 1990); *see also In re* Estate of Zielinski, 623 N.Y.S.2d 653 (App. Div. 1995).

57. *In re* Estate of Strittmatter, 53 A.2d 205, 206 (N.J. 1947).

Both the undue influence and insane delusion doctrines developed as equitable remedies aimed at protecting those whose decisional failings "fell short of total lack of legal capacity":

> The "wrong" involved in undue influence ... was the interference with another's will, which should ideally be free. The test for the existence of undue influence became the presence or absence of "free agency," whether or not the individual will had been "overpowered."[58]

Similar concerns about free agency are also evident in various exculpatory doctrines employed by the criminal law; "the doctrines of duress, provocation, necessity, and self-defense are exculpatory or mitigating because the actor can explain the criminal act in terms of unusual exogenous pressures and not moral deficiency."[59] Modern definitions of insanity that look to the defendant's ability to conform her conduct to the law's dictates are similarly reliant on the principle that an actor should not be held responsible for acts over which he had no meaningful control.[60]

Not every area of law has placed the same emphasis on free agency. The law of torts, for example, evidences a highly ambivalent approach. Negligence law takes the actor's age and mental state into account in determining his culpability,[61] but the law of intentional torts does not; the mentally ill tort defendant who strikes the plaintiff based on a delusion that he is under attack is held accountable for compensatory damages to the same extent as the defendant who strikes the plaintiff with malice aforethought.[62] The

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58. John P. Dawson, *Economic Duress—An Essay in Perspective*, 45 MICH. L. REV. 253, 262-63 (1947).

59. Elizabeth S. Scott & Laurence Steinberg, *Blaming Youth*, 81 TEX. L. REV. 799, 826 (2003) (footnote omitted). *See generally* HART, *supra* note 2, at 28-51, 186-209; Joshua Dressler, *Reflections on Excusing Wrongdoers: Moral Theory, New Excuses and the Model Penal Code*, 19 RUTGERS L.J. 671 (1988); Stephen J. Morse, *Culpability and Control*, 142 U. PA. L. REV. 1587 (1994).

60. *See* MODEL PENAL CODE § 4.01(1) (1985) ("A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.").

61. *See* RESTATEMENT (THIRD) OF TORTS §§ 8-10 (Discussion Draft 1999).

62. *See* McGuire v. Almy, 8 N.E.2d 760, 763 (Mass. 1937); RESTATEMENT (SECOND) OF TORTS §§ 16, 283B (1965).

torts approach has been criticized, but it has also been justified based on a fundamental goal of tort law, that of compensating those injured through no fault of their own.[63]

The criminal law also expresses ambivalence about free agency. Although a number of jurisdictions adopted one or another modern definition of insanity that takes account of the actor's capacity to control his conduct, some have since returned to the traditional cognitive insanity test based on concerns that the modern definition may negatively affect public safety.[64] Similar concerns underlie the criminal law's frequent willingness to classify as crimes acts to which the "victim" consented.[65]

The extent to which different areas of law take account of factors that interfere with volition thus tends to vary in accordance with underlying goals. The law of wills is dominated by the principle of freedom of testation; it is not surprising that it would insistently take account of factors that might affect the authenticity of the testator's expressed wishes or that it would develop doctrines aimed at ferreting out more subtle forms of coercion than those captured by mainstream notions of force, fraud, and duress. Nor is it surprising that areas of law concerned with public safety and victim compensation would evidence more ambivalence about investigation of mental state.

### *C. The Law of Medical Decision Making: A Puzzling Exception to the Dominant Pattern*

The law of medical decision making offers a puzzling exception to the pattern evident in other areas of law. Health care law is

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63. *See* Seals v. Snow, 254 P. 348, 349 (Kan. 1927) ("[W]here one of two innocent persons must suffer a loss, it should be borne by the one who occasioned it."); Gould v. Am. Family Mut. Ins. Co., 543 N.W.2d 282, 285 (Wis. 1996) ("[W]here a loss must be borne by one of two innocent persons, it shall be borne by him who occasioned it, and ... public policy requires the enforcement of the liability in order that those interested in the estate of the insane person, as relatives or otherwise, may be under inducement to restrain him ...."). *See generally* Francis H. Bohlen, *Liability in Tort of Infants and Insane Persons*, 23 MICH. L. REV. 9 (1924).

64. *See* HART, *supra* note 2, at 186-209 (providing a historical account of insanity rules in Great Britain and describing opposition to modern "capacity to control conduct" definitions of insanity as based on concerns with shamming and the view that criminal law should be concerned primarily with crime prevention).

65. *See generally* 2 JOEL FEINBERG, THE MORAL LIMITS OF THE CRIMINAL LAW: OFFENSE TO OTHERS (1985); Jessica Wilen Berg, *Understanding Waiver*, 40 HOUS. L. REV. 231 (2003).

dominated by the principle of patient autonomy,[66] a principle not far removed from the ideal of testatory freedom that underlies the law of wills. Both of these principles focus on effectuating an actor's authentic intentions, and volition is undeniably a fundamental aspect of authenticity.[67] One would thus expect that the law of medical decision making would have developed a range of doctrines, like the undue influence and insane delusion rules, aimed at preventing the enforcement of inauthentic choices.

Certainly, courts have long held that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body"[68] and, based on this principle, they have uniformly concluded that the physician who treats the patient without his consent is liable for battery.[69] This is why the British researchers who surveyed emergency-room physicians warned doctors who would treat the patient without her consent that they were at risk of legal liability.[70] More recently, courts have developed the doctrine of "informed consent" to protect the patient's right to make a decision based on accurate information about the risks and benefits of the procedure in question; a physician's failure to accurately describe material risks and benefits that the typical decision maker would rely upon is actionable if the decision maker can show that he or she detrimentally relied on an erroneous risk/benefit statement.[71]

Although the informed consent claim takes account of coercive *informational* influences, it does not address mental, contextual, or emotional factors that might overpower the decision maker's will, like those recognized in the undue-influence and insane-delusion doctrines. The bioethics literature does stress voluntariness and "conditions free of coercion and undue influence" as essential

66. *See* sources cited *supra* note 9.

67. *See, e.g.*, TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 106 (3d ed. 1989) ("Being free to act is sometimes as important for autonomous action as being competent and being informed.").

68. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

69. *See, e.g.*, Bang v. Charles T. Miller Hosp., 88 N.W.2d 186, 189-90 (Minn. 1958); Mohr v. Williams, 104 N.W. 12, 14-16 (Minn. 1905). *See generally* Allan H. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957).

70. *See* Hassan et al., *supra* note 38, at 109.

71. The informed consent claim was pioneered in *Canterbury v. Spence*, 464 F.2d 772, 780-85 (D.C. Cir. 1972), and *Cobbs v. Grant*, 502 P.2d 1, 7-8 (Cal. 1972). For a detailed account of informed consent doctrine, see GARRISON & SCHNEIDER, *supra* note 9, at 27-96.

components of autonomous decision making,[72] but the law of medical decision making has never developed doctrines that take noninformational forms of coercion and undue influence into account. The medical decision induced by grief, shock, or despair is enforceable to the same extent as one induced by a careful appraisal of the patient's long-term goals and values.

In recent years, there has been some movement toward a more contextual analysis in two isolated, and very different, contexts. A few courts have mandated consideration of noncognitive factors when evaluating the competence of psychotic patients who wish to decline treatment with antipsychotic drugs. For example, in *Rivers v. Katz*, the New York Court of Appeals ruled that competence to decline anti-psychotic drugs—the only treatment for schizophrenia and related disorders—should be based not just on "ability to understand the available options" and "cognitive capacity to consider the relevant factors," but also on

> the absence of any interfering pathologic perception or belief, such as a delusion concerning the decision; ... the absence of any interfering emotional state, such as severe manic depression, euphoria or emotional disability; ... the absence of any interfering pathologic motivational pressure; ... the absence of any interfering pathologic relationship, such as the conviction of helpless dependency on another person; [and] ... an awareness of how others view the decision, the general social attitude toward the choices and an understanding of his reason for deviating from that attitude if he does.[73]

The Oregon Death with Dignity Act, the nation's only law authorizing physician-assisted suicide (PAS), also takes noncognitive factors into account. The Act requires the attending physician to refer for counseling any patient who "may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment"[74] and directs that "[n]o medication to end a patient's life ... shall be prescribed until the person performing the

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72. NAT'L COMM'N FOR THE PROT. OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, THE BELMONT REPORT 14 (1978); *see also* BEAUCHAMP & CHILDRESS, *supra* note 67, at 106-07.

73. Rivers v. Katz, 495 N.E.2d 337, 344 n.7 (N.Y. 1986).

74. OR. REV. STAT. § 127.825 (2007).

counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[75]

These isolated deviations from the traditional "understanding is enough" approach have not had any larger impact on the law of medical decision making, however. Indeed, even with respect to anti-psychotic drug treatment, many courts continue to utilize purely cognitive tests in evaluating medication refusals, and a growing literature on the capacity of psychotic patients to consent to psychiatric research uniformly assumes that traditional, cognitive competence tests will be used to determine the participation of potential research subjects.[76]

The current law of medical decision making thus exhibits a far more anemic response to potentially coercive influences than does the law of wills, or even the law of contracts and marriage. In these other areas of law, cognitive tests of decision-making capacity are typically coupled with equitable doctrines that assess a broad range of factors—physical, informational, emotional, perceptual—that might compel the actor's choice. Because the law of medical decision making assesses only physical and informational forms of coercion,[77] it offers considerably less protection to vulnerable actors.

At first blush, this pattern seems extremely odd. The law of medical decision making is not centrally, or even peripherally, concerned with compensation, deterrence, or public safety, the concerns that justify tort and criminal law's wavering response to coercive influences. Indeed, quite to the contrary, virtually every aspect of medical decision making can be, and typically is, analyzed in terms of patient autonomy. Autonomy has come to play a "preemptive role" in discourse about patient decision making and care.[78]

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75. *Id.*

76. *See generally* L.B. Dunn, *Capacity to Consent to Research in Schizophrenia: The Expanding Evidence Base*, 24 BEHAV. SCI. & L. 431 (2006) (reviewing studies); *supra* notes 13-14.

77. *See supra* notes 66-72 and accompanying text.

78. *See* Daniel Callahan, *Can the Moral Commons Survive Autonomy?*, HASTINGS CTR. RPT., Nov.-Dec. 1996, at 41, 41; *see also* GARRISON & SCHNEIDER, *supra* note 9, at 14, 1091-93; SCHNEIDER, *supra* note 9, at 3-9.

If the law of medical decision making is centrally, preemptively concerned with autonomy, why has it failed to develop equitable doctrines like those evident in the law of wills? One explanation is historical. The autonomy principle that now dominates medical decision making has achieved prominence only within the past thirty to forty years.[79] In earlier times, doctors typically obfuscated treatment risks or sugar-coated information about the patient's medical situation when they felt that such actions had therapeutic value; sometimes, the evidence suggests, they acted without obtaining the patient's consent to treatment at all.[80] This older approach, an outgrowth of the Hippocratic injunction to act for the benefit of the sick, placed less emphasis on the patient's considered opinion and more on his medical interests. It produced a decision-making climate in which treatment refusals were rare and litigation about such refusals even rarer.

A second explanation is practical. Even today, when autonomy is the central theme in health-care decision making, patients are highly prone to accept their doctors' treatment advice.[81] This tendency results from two simple facts: patients typically want to get better, and patients typically believe they are most likely to get better when guided by a professional trained in the art of producing such betterment.

If the patient makes an incompetent or coerced decision that results in a medically recommended treatment, it is tempting to ignore evidence of incompetence or coercion. After all, a finding that a particular decision is incompetent or coerced will lead to the appointment of a guardian charged with making a decision in the best interests of the patient,[82] and the best interests of the patient

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79. *See* Eric J. Cassell, *The Principles of the Belmont Report Revisited: How Have Respect for Persons, Beneficence, and Justice Been Applied to Clinical Medicine?*, HASTINGS CTR. RPT., July-Aug. 2000, at 12, 12-13.

80. *See id.*

81. Although patients overwhelmingly accept treatment recommendations, they may not follow through on them. *See* Buzz McClain, *Tell Me Where It Hurts: Doctors and Patients Often Let Each Other Down*, WASH. POST, Feb. 6, 2007, at F1 (describing national survey finding that, although 59 percent of doctors said that patients' noncompliance with treatment recommendations was their "main complaint," most patients said that they "completely followed" their doctors' recommendations).

82. *See* cases cited *supra* notes 26-37.

will almost always mandate a decision in favor of whatever medical intervention the doctor has recommended.

We do not know just how many incompetent or coerced decisions medical professionals accept, but the evidence suggests that the numbers are substantial. For example, one survey of mental patients who had "voluntarily" entered inpatient treatment revealed that 44 percent would not pass a standard cognitive competence test.[83] And researchers who conducted a similar survey of acutely ill medical inpatients concluded that at least 40 percent lacked decision-making capacity; clinical teams "rarely" identified these patients.[84]

The existence of historical and practical explanations for the parsimonious approach does not, of course, provide an adequate justification for its continued use. History and past practice are, as Justice Holmes put it, only "the first step toward an enlightened skepticism, that is, toward a deliberate reconsideration of the worth of those rules."[85] Deliberate reconsideration requires an assessment of whether the parsimonious approach comports with the current goals and values of the law of medical decision making. If it does not, it should be rejected.

## II. IS CURRENT LAW ADEQUATE TO ENSURE PATIENT AUTONOMY?

### *A. Possible Justifications for the Parsimonious Approach*

One possible justification for the parsimonious approach is efficiency. We have already seen that medical providers appear to routinely ignore evidence of incompetence when the patient accepts a recommended treatment, likely based on an efficiency rationale; after all, a judicial finding of incompetence will almost certainly lead, directly or through the appointment of a guardian, to a decision in favor of the same treatment the patient has already elected. Extrapolating from this fact, some experts have argued that

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83. *See* B.F. Hoffman & J. Srinivasan, *A Study of Competence To Consent to Treatment in a Psychiatric Hospital*, 37 CAN. J. PSYCHIATRY 179, 181 (1992).

84. *See* Vanessa Raymont et al., *Prevalence of Mental Incapacity in Medical Inpatients and Associated Risk Factors: Cross-sectional Study*, 364 LANCET 1421, 1421 (2004).

85. Oliver Wendell Holmes, Jr., *The Path of the Law*, *in* THE MIND AND FAITH OF JUSTICE HOLMES 83 (Max Lerner ed., 1943).

competence standards themselves should vary based on risk. For example, the American Psychiatric Association Task Force on Consent to Voluntary Hospitalization has urged that, for purposes of voluntary admission to a psychiatric hospital, a patient should be considered competent whenever he knows that he is entering a hospital and that release is not automatic:

> Under the Task Force's approach, the patient would ... not ... need to demonstrate an appreciation of the treatment (e.g., a patient who thought that treatment would be effective because of interference from ultra-violet light waves emanating from overhead fixtures may still be considered competent to admit himself). This minimal standard of competence may be warranted, the APA Task Force argued, because of the low risk of harm from voluntary hospitalization, particularly when the patient's choice is confirmed by an independent professional judgment, as well as society's interest in encouraging individual choice in this context.[86]

Expanding on the Task Force's argument, one can make a case for minimal intervention standards whenever the patient decides in favor of a recommended medical treatment.[87] In such a case, there is no obvious harm in honoring the patient's nonautonomous decision, nor is there any obvious reason for undertaking an elaborate exercise in substitute decision making that will produce exactly the same result as that which the patient has already elected.[88]

The Task Force position also provides an argument in favor of minimal intervention standards when a proposed treatment offers

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86. *See* Berg et al., *supra* note 10, at 379.

87. For arguments in favor of this approach, see generally D.W. Brock, *Decisionmaking Competence and Risk*, 5 BIOETHICS 105 (1991); Allen Buchanan & Dan W. Brock, *Deciding for Others*, 64 MILBANK Q. (SUPP. 2) 17 (1986); Ian Wilks, *The Debate over Risk-Related Standards of Competence*, 11 BIOETHICS 413 (1997). For criticism of risk-related competence standards, see generally Joseph P. DeMarco, *Competence and Paternalism*, 16 BIOETHICS 231 (2002); M. Parker, *Competence by Consequence: Ambiguity and Incoherence in the Law*, 25 MED. & L. 1 (2006); M.R. Wicclair, *Patient Decision-making Capacity and Risk*, 5 BIOETHICS 91 (1991).

88. There is evidence that clinicians take risk factors into account in assessing competence. *See* Scott Y.H. Kim et al., *Do Clinicians Follow a Risk-sensitive Model of Capacity-Determination? An Experimental Video Survey*, 47 PSYCHOSOMATICS 325, 328 (2006).

only marginal improvement in the patient's condition or itself poses serious risks. In these cases, too, the chance that the patient's interests will be seriously harmed is low, and natural variation in risk aversion and personal values would lead us to expect that autonomous decision makers will frequently disagree. Indeed, the doctrine of informed consent is based on the assumption that a careful risk-benefit analysis will lead many autonomous patients to elect against treatment.[89] Such variation enhances the difficulty of determining which choices are genuinely nonautonomous and of determining what choice the nonautonomous actor would have made if he were acting as an autonomous agent.

However, the Task Force approach does not support use of the parsimonious approach when the patient's decision will result in the loss of large and fairly certain benefits. Physician-assisted suicide, one of the cases in which we have seen some movement away from the parsimonious model, offers a particularly vivid example of such a case: PAS will invariably shorten the patient's life; it may also significantly reduce opportunities of both the patient and her family for sharing and mutually coming to terms with their impending loss.

Antipsychotic drug treatment, the other context in which some courts have deviated from the parsimonious model, offers another compelling example of a decision-making context in which non-treatment risks the loss of substantial, and substantially certain, benefits. Antipsychotic drugs are the only treatment for schizophrenia, and untreated schizophrenia is extraordinarily debilitating and dangerous. Relatively few untreated schizophrenics can live independently, and many thus wind up on the streets or behind bars;[90] fully half abuse drugs or alcohol, and more than 10 percent

89. *See* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986); Peter Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 918 (1994).

90. *See* Johann Brink, *Epidemiology of Mental Illness in a Correctional System*, 18 CURRENT OPINION PSYCHIATRY 536, 536 (2005) ("The prevalence of psychiatric illness in correctional settings is significantly elevated .... It is estimated that in the USA one in five incarcerated persons is afflicted with major psychiatric illness; with an estimated 9-10 million persons imprisoned worldwide ...."); *see also* Dale E. McNeil et al., *Incarceration Associated with Homelessness, Mental Disorder, and Co-occurring Substance Abuse*, 56 PSYCHIATRY SERV. 840, 842-43 (2005) (reporting that 16 percent of episodes of incarceration involved homeless inmates; in 18 percent of episodes, the inmates had a diagnosis of a mental disorder; 30 percent of the inmates who were homeless had a diagnosis of a mental disorder during one or more episodes; and 78 percent of the homeless inmates with a severe mental disorder had co-occurring substance-related disorders).

succeed in killing themselves.[91] Antipsychotic drugs can enable most schizophrenic patients to live outside an institution and lead relatively normal lives. But approximately half of schizophrenic patients in unsupervised settings fail to take prescribed medications,[92] and delayed or sporadic use of antipsychotics worsens a schizophrenic patient's prognosis.[93] Moreover, accumulating research evidence suggests that medication noncompliance is strongly associated with the risk of violence toward others.[94]

Given that decisions in favor of PAS and against antipsychotic drug treatment have the potential to impose serious harm on the patient, his family, and, in the case of antipsychotic drug treatment, the public, it is easy to see why courts and legislatures have begun to move away from the parsimonious approach in these contexts. And if PAS and antipsychotic drug treatment were the *only* contexts in which nonautonomous decisions typically failed to serve the patient's best interests, it would make sense to retain the parsimonious approach along with limited volitional doctrines tailored specifically to these decision-making contexts. After all, the doctrines of duress, fraud, insane delusion, and undue influence all arose in specific, recurring contexts and are tailored to those contexts.

However, while PAS and antipsychotic drug treatment represent recurring fact patterns that illustrate the range of serious harms that may arise from a medical decision, many decisions against treatment present equivalent risks of serious harm: Mrs. Candura's

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91. *See* Peter J. Weiden et al., *Expert Consensus Treatment Guidelines for Schizophrenia*, 60 J. CLINICAL PSYCHIATRY (SUPP. 11) 1, 78 (1999).

92. *See* Joseph P. McEvoy, *The Relationship Between Insight into Psychosis and Compliance with Medications*, *in* INSIGHT & PSYCHOSIS 311, 325 (Xavier F. Amador & Anthony S. David eds., 2d ed. 2004) [hereinafter INSIGHT & PSYCHOSIS 2d ed.] (summarizing research).

93. *See* Mary Clarke et al., *Untreated Illness and Outcome of Psychosis*, 189 BRIT. J. PSYCHIATRY 235, 238 (2006) (finding that a longer duration of untreated psychosis was associated with a significantly poorer functional and symptomatic outcome four years later); World Fellowship for Schizophrenia & Allied Disorders, New Treatments for Schizophrenia, http://www.world-schizophrenia.org/publications/02-treatments.html (last visited Nov. 30, 2007) (reporting, based on review of more than twenty different studies, that patients who started antipsychotic medications within a few months of the first psychotic episode had significantly fewer relapses and subsequent hospitalizations as well as significantly better prospects of returning to a healthier lifestyle).

94. *See* E. Fuller Torrey, *The Relationship of Insight to Violent Behavior and Stigma*, *in* INSIGHT & PSYCHOSIS 2d ed., *supra* note 92, at 243, 246-47 (reviewing studies).

decision to forgo surgery shortened her life as surely as would a decision to undertake PAS; so did Mr. Quackenbush's decision against amputation, Mr. Bergstadt's decision to forgo respirator care, Ms. Bouvia's decision to forgo tube feeding, and the lucid suicide victim's decision to forgo gastric lavage.[95] Indeed, because none of these patients was terminally ill, each nontreatment decision had the capacity to produce greater loss of life, experience, and productive existence than would an Oregon PAS decision, statutorily limited to patients with no more than a six-month life expectancy.[96] If the risks inherent in a nontreatment decision mandate consideration of coercive influences in the case of PAS, it would seem that they should also mandate consideration of these influences in these other cases. Certainly, there is no basis grounded in potential harm to the patient for distinguishing the case in which a patient forgoes life-saving treatment from the case in which the patient elects PAS.

This is not to say that PAS and antipsychotic drug treatment cannot be distinguished from the general run of medical decisions that seriously conflict with the patient's medical interests. Antipsychotic drug treatment appears to protect the public as well as the patient by reducing the propensity toward violence;[97] this factor alone might justify policies, like those utilized in tort law, that pay less heed to the voluntariness of an actor's conduct. PAS is a novel form of medical "care" that many medical ethicists believe to be fundamentally inconsistent with the physician's ethical obligation to act for the patient's benefit;[98] novelty and uncertain ethicality arguably mandate special measures to ensure the authenticity of patient choice.

However, if autonomy is a central goal in the law of health-care decision making—and for at least thirty years commentators of every persuasion have uniformly assumed that it is—then the law should be structured to ensure that *all* nonautonomous choices

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95. *See supra* notes 16-37 and accompanying text.

96. *See* OR. REV. STAT. § 127.800(1.01)(12) (2005).

97. *See* Torrey, *supra* note 94 (summarizing evidence).

98. *See, e.g.*, Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 881-82 (1992); David Orentlicher, *The Legalization of Physician-assisted Suicide*, 335 NEW ENG. J. MED. 663, 663-64 (1996).

which seriously conflict with the patient's medical interests are not enforced.

Such an approach would have the additional merit of bringing the law of medical decision making into conformity with the law of wills, which is also centrally concerned with effectuating autonomous choices. Both the undue-influence and insane-delusion doctrines ignore as harmless a potentially coercive influence when it produces results consistent with the typical decedent's preference for immediate family. However, when the testator leaves his assets to an individual who is not among the "natural objects of his bounty" as a result of a coercive influence, the bequest is struck down.[99] Surely the law of medical decision making should offer equal protection against coercion. After all, the law of wills protects only wealth; the law of medical decision making protects health and life itself.

Of course, there might be practical reasons to eschew a search for coercive influences. If, for example, genuinely coercive influences were extremely rare or difficult to detect, the costs of such a search might well outweigh the potential benefits. A cost-benefit analysis would also lead us away from an inquiry into coercive influences if we lacked clear evidence as to the types of influences that are coercive. But to the extent that there is clear evidence of influences that are both coercive and readily detectible, the law's focus on patient autonomy argues strongly in favor of an inquiry into these influences as a precondition to enforcing a decision that seriously conflicts with the patient's medical interests.[100]

### *B. The Evidence: Conditions that Coerce*

Although the research evidence is inadequate to make definitive statements about the range of influences that might coerce significant numbers of patient choices, it does identify two fairly common

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99. *See, e.g.*, *In re* Kamesar, 259 N.W.2d 733, 739 (Wis. 1977) (describing "naturalness or expectedness of the bequest" as an element of the undue-influence claim and noting that "[t]he fact that the testator has excluded a natural object of his bounty is 'red flag of warning'").

100. *Cf.* Ken Kress, *Why Lack of Insight Should Have a Central Place in Mental Health Law*, *in* INSIGHT & PSYCHOSIS 2d ed., *supra* note 92, at 261-66 (arguing that coerced treatment should be justified by conditions that are objectively discernible, material, outcome-independent, and ethically significant and that impaired insight satisfies all these conditions).

conditions that interfere with freedom of choice and produce decisions against medical interests.

*1. Disordered Insight*

The patient with insight can recognize the nature and severity of her illness, correctly attribute symptoms to that illness, comprehend the risks and benefits of treatment, and make a treatment choice based on her personal goals and values.[101] The patient without insight suffers impairment in one or more of these capacities.

Extreme lack of insight will prevent a patient from passing a standard, cognitive test of competence. The patient who lacks all knowledge that she is ill will not be able to demonstrate an appreciation that the treatment choice is relevant to her own situation.[102] Thus, for example, had Mrs. Candura argued that her gangrenous leg was healthy, the appellate court would almost certainly have declared her incompetent.

However, insight deficits are often variable and partial. Such a deficit may manifest itself as:

1. Failure to recognize signs, symptoms, or disease ...
2. Misattribution of the source or cause of signs, symptoms, or disease
3. Failure to appreciate the implausibility of perceptual experiences or beliefs
4. Failure to derive appropriate cognitive representations despite recognition of pathological signs, symptoms, or disease
5. Inappropriate affective reactions despite recognition of pathological signs, symptoms, or disease
6. Inappropriate behavioral responses (actions) despite recognition of pathological signs, symptoms, or disease[103]

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101. *See* K. William M. Fulford, *Completing Kraepelin's Psychopathology: Insight, Delusion, and the Phenomenology of Illness*, *in* INSIGHT AND PSYCHOSIS 47, 47-48 (Xavier F. Amador & Anthony S. David eds., 1998) [hereinafter INSIGHT & PSYCHOSIS 1st ed.]; Bonnie L. Rickelman, *Anosognosia in Individuals with Schizophrenia: Toward Recovery of Insight*, 25 ISSUES IN MENTAL HEALTH NURSING 227, 229-30 (2004).

102. *See supra* text accompanying notes 23-25.

103. Harold A. Sackeim, *Introduction: The Meaning of Insight*, *in* INSIGHT & PSYCHOSIS 1st ed., *supra* note 101, at 3, 8.

The patient may be aware of some symptoms but not others; her level of awareness may shift from day to day or even hour to hour; she may be aware of past but not present illness, or of present illness but not past; her knowledge of her illness may be divorced from her emotional response to it.

Insight deficits derive from a variety of causes. They may result from traumatic brain injury or neurological damage suffered in a stroke or other vascular accident.[104] They often accompany Alzheimer's Disease and other forms of dementia.[105] Insight deficits are also frequently associated with mental illness. Such disorders are common among patients suffering from a range of psychiatric maladies, including substance abuse and bipolar, schizo-affective, obsessive-compulsive, and eating disorders;[106] they are particularly prevalent among schizophrenic patients. Researchers have reported that 60 percent to 90 percent of schizophrenics fail to comprehend that they are ill and that equal numbers experience nonawareness of specific symptoms associated with their illness.[107] Indeed, in

104. *See* William B. Barr, *Neurobehavioral Disorders of Awareness, in* INSIGHT & PSYCHOSIS 1st ed., *supra* note 101, at 107-20.

105. *See* C. Antoine et al., *Awareness of Deficits and Anosognosia in Alzheimer's Disease*, 30 ENCEPHALE 570 (2004) (reviewing studies of loss of insight in Alzheimer's Disease); Mario F. Mendez & Jill S. Shapira, *Loss of Insight and Functional Neuroimaging in Frontotemporal Dementia*, 17 J. NEUROPSYCHIATRY CLINICAL NEUROSCI. 413, 413 (2005) (noting that loss of insight is diagnostic criterion for frontotemporal dementia and that it is often exhibited as a lack of concern rather than a lack of awareness); K.P. Rankin et al., *Self Awareness and Personality Change in Dementia*, 76 J. NEUROLOGY & NEUROSURGICAL PSYCHIATRY 632, 632, 636-37 (2005) (reporting that loss of insight is a core diagnostic criterion for frontotemporal dementia while failure to recognize cognitive deficits and unawareness of disease are well established findings in Alzheimer's Disease).

106. *See* S. Nassir Ghaemi & Klara J. Rosenquist, *Insight in Mood Disorders: An Empirical and Conceptual Review, in* INSIGHT & PSYCHOSIS 2d ed., *supra* note 92, at 101-13 (summarizing literature on insight deficits associated with bipolar and other mood disorders); Thomas F. Cash & Edwin A. Deagle III, *The Nature and Extent of Body-Image Disturbances in Anorexia Nervosa and Bulimia Nervosa: A Meta-Analysis*, 22 INT'L J. EATING DISORDERS 107, 108, 116 (1997) (describing insight deficits in the form of distorted body image among patients with eating disorders); Domenico De Berardis et al., *Insight and Alexithymia in Adult Outpatients with Obsessive–Compulsive Disorder*, 255 EUR. ARCHIVES PSYCHIATRY & CLINICAL NEUROSCI. 350, 350, 354 (2005) (describing insight deficits in obsessive-compulsive patients); Barbara S. McCrady & Donald A. Bux, Jr., *Ethical Issues in Informed Consent with Substance Abusers*, 67 J. CONSULTING & CLINICAL PSYCHOL. 186, 187, 193 (1999) (describing insight deficits associated with substance abuse); J. Scott Mizes et al., *The Validity of Subjective Measures of Body Image Disturbance*, 5 EATING BEHAV. 55, 56, 64 (2004) (describing insight deficits in the form of distorted body image among patients with eating disorders).

107. *See* Xavier F. Amador & Henry Kronengold, *The Description and Meaning of Insight*

one survey, only 4 of 102 schizophrenic patients interviewed reported "at least one negative symptom as a direct manifestation of mental disease—that is, not secondary to other symptoms or to medication."[108]

In the case of disordered insight associated with brain or neurological injury, imaging studies suggest that impairment is due to cortical, thalamic, and nerve lesions.[109] Building on these studies, medical researchers have more recently found that schizophrenics also display characteristic neuroanatomic abnormalities and that higher levels of abnormality are associated with higher levels of disease pathology and more substantial insight deficits.[110] Thus, according to the standard manual for psychiatric assessment, "poor insight [in schizophrenia] is a manifestation of the illness ... comparable to the lack of awareness of neurological deficits seen in stroke ...."[111]

Disordered insight appears to be related to impairment in what neurologists describe as "executive function," which includes

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*in Psychosis*, *in* INSIGHT & PSYCHOSIS 2d ed., *supra* note 92, at 1, 16-18 (summarizing research and describing studies finding that 60 percent of surveyed schizophrenics displayed moderate to severe unawareness of having a mental disorder and that between 27 percent and 87 percent of schizophrenics were unaware of specific symptoms); Robert C. Schwartz, *The Relationship Between Insight, Illness and Treatment Outcome in Schizophrenia*, 69 PSYCHIATRIC Q. 1, 3 (1998) (reporting that two different studies found that 90 percent of schizophrenics exhibited poor insight and that almost 60 percent exhibited moderate to severe lack of insight). Violence among schizophrenics is also significantly correlated with impaired insight. *See* Torrey, *supra* note 94, at 246 (summarizing research).

108. Jean-Paul C.J. Selten et al., *The Subjective Experience of Negative Symptoms*, *in* INSIGHT & PSYCHOSIS 1st ed., *supra* note 101, at 78, 85.

109. *See* Barr, *supra* note 104, at 112-15.

110. *See* Frank Larøi et al., *The Neuropsychology of Insight in Psychiatric and Neurological Disorders*, *in* INSIGHT AND PSYCHOSIS 2d ed., *supra* note 92, at 119, 132-33 (summarizing studies); Brett Shurman et al., *Schizophrenia Patients Demonstrate a Distinctive Pattern of Decision-Making Impairment on the Iowa Gambling Task*, 72 SCHIZOPHRENIA RES. 215, 215 (2005) (reporting that tested schizophrenics "displayed a pattern of compromised decision-making ... somewhat distinct from that found in [orbitofrontal cortex] lesion patients and that may be linked to certain clinical symptoms"); Schizophrenia.com, The Neurological Basis for Impaired Insight in Schizophrenia: A Review of the Research, http://www.schizophrenia.com/insightbiology.htm (last visited Nov. 30, 2007) (reviewing research); *see also* Laura A. Flashman et al., *Specific Frontal Lobe Subregions Correlated with Unawareness of Illness in Schizophrenia: A Preliminary Study*, 13 J. NEUROPSYCHIATRY & CLINICAL NEUROSCI. 255, 256 (2001); Matcheri S. Keshavan et al., *Correlates of Insight in First Episode Psychosis*, 70 SCHIZOPHRENIA RES. 187, 190 (2004).

111. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS IV-TR 304 (4th ed. 2000).

capacities relating to the ability to plan, initiate, sequence, monitor, and inhibit.[112] Like insight itself, executive function appears to originate in the prefrontal cortex of the brain, and it has been most extensively studied in patients with brain lesions. Lesions in any cortical area appear to affect executive control and thereby to "interfere with intentionality and voluntariness."[113] Although brain injuries produce the clearest instances of executive dysfunction, imaging studies have shown neuroanatomic abnormalities associated with executive dysfunction in the context of many other illnesses. These include physical disorders such as hypertension, stroke, and diabetes;[114] various forms of dementia;[115] prolonged alcohol or drug abuse;[116] and psychiatric diseases such as schizo-

112. Jason E. Schillerstrom et al., *The Impact of Medical Illness on Executive Function*, 46 PSYCHOSOMATICS 508, 511 (2005) (noting that executive function is "associated with a person's ability to make decisions, their capacity to carry out a plan ....").

113. Anna L. Grimes et al., *Informed Consent and Neuroanatomic Correlates of Intentionality and Voluntariness Among Psychiatric Patients*, 51 PSYCHIATRY SERVS. 1561, 1562-63 (2000) ("Lesions in [one] ... pathway may produce a 'dysexecutive' syndrome, in which thinking becomes disorganized and concrete and the patient has difficulty with abstraction and with multistep tasks.... Lesions in [another] ... pathway ... result in an 'apathetic' syndrome, in which patients become passive and often lose all interest in their financial and personal affairs.... Deficits in [yet another] ... area produce a 'disinhibited' syndrome with affective lability, insensitivity, tactlessness, and in some cases, unpredictable aggressive outbursts.... With ... lesions of [multiple cortical regions] ..., patients may show 'stimulus-bound' behavior, in which they are overly affected by environmental cues.").

114. *See* Dino Muslimović, *Cognitive Profile of Patients with Newly Diagnosed Parkinson Disease*, 65 NEUROLOGY 1239 (2005) (finding that 24 percent of newly diagnosed Parkinson's Disease patients displayed defective performance on at least three neuropsychological tests and that the most common deficits were in the domains of memory and executive functions).

115. *See* Bruce R. Reed et al., *Effects of White Matter Lesions and Lacunes on Cortical Function*, 61 ARCHIVES NEUROLOGY 1545, 1545-46 (2004) (describing executive-function impairments in patients with ischemic vascular dementia and hypothesizing relationship to brain lesions); Margaret M. Swanberg et al., *Executive Dysfunction in Alzheimer Disease*, 61 ARCHIVES NEUROLOGY 556, 558-59 (2004) (finding that 64 percent of tested AD patients had executive-function deficits and that less than 30 percent of the variance in performance was explained by cognitive measures). Among patients reporting memory problems, deficits in executive function are also strong predictors of conversion to Alzheimer's Disease. *See* Matthias H. Tabert et al., *Neuropsychological Prediction of Conversion to Alzheimer Disease in Patients With Mild Cognitive Impairment*, 63 ARCHIVES GEN. PSYCHIATRY 916 (2006).

116. *See* Xavier Nöel et al., *Supervisory Attentional System in Nonamnesic Alcoholic Men*, 58 ARCHIVES GEN. PSYCHIATRY 1152, 1152 (2001); Antonio Verdejo-García & Miguel Pérez-García, *Profile of Executive Deficits in Cocaine and Heroin Polysubstance Users: Common and Differential Effects on Separate Executive Components*, 190 PSYCHOPHARMACOLOGY 517, 517 (2007).

phrenia and obsessive-compulsive disorder.[117] Indeed, some evidence suggests that "executive function and attention deficits may be core features of schizophrenia,"[118] which would explain why insight deficits are so common in this population.[119]

Although the origin of insight impairments and their relationship to executive-function deficits are still not fully understood,[120] insight impairments can be accurately diagnosed. A number of different assessment tools have been developed, including the Scale to Assess Unawareness of Mental Disorder (SUMD), the Insight and Treatment Attitude Questionnaire (ITAQ), and the Beck Cognitive Insight Scale (BCIS).[121] When used by experienced clinicians, many

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117. *See* Robert M. Roth et al., *Speed and Accuracy on Tests of Executive Function in Obsessive-Compulsive Disorder*, 54 BRAIN & COGNITION 263, 263 (2004); Schillerstrom et al., *supra* note 112, at 508; Daniel R. Weinberger & Karen Faith Berman, *Speculation on the Meaning of Cerebral Metabolic Hypofrontality in Schizophrenia*, 14 SCHIZOPHRENIA BULL. 157, 165 (1988); Kriscinda A. Whitney et al., *Comparative Neuropsychological Function in Obsessive-Compulsive Disorder and Schizophrenia With and Without Obsessive-Compulsive Symptoms*, 69 SCHIZOPHRENIA RES. 75, 81 (2004); Richard H. Workman et al., *Clinical and Ethical Implications of Impaired Executive Control Functions for Patient Autonomy*, 51 PSYCHIATRY SERV. 359, 359 (2000).

118. Thomas W. Weickert et al., *Cognitive Impairments in Patients with Schizophrenia Displaying Preserved and Compromised Intellect*, 57 ARCHIVES GEN. PSYCHIATRY 157, 157 (2000).

119. *See generally supra* notes 106-07.

120. For example, investigators attempting to correlate impaired insight with specific types of executive function impairment in a population of schizophrenic patients have reported that their results "suggest [that] insight may be related to capacities to shift attention between differing environmental demands, plan ahead, and construct contextual understandings." Paul H. Lysaker et al., *Awareness of Illness in Schizophrenia: Associations with Multiple Assessments of Executive Function*, 18 J. NEUROPSYCHIATRY & CLINICAL NEUROSCI. 516, 516 (2006); *see also* Paul H. Lysaker et al., *Insight in Schizophrenia: Associations with Executive Function and Coping Style*, 59 SCHIZOPHRENIA RES. 41, 41-42 (2003). But schizophrenic patients may exhibit serious insight deficits in the absence of executive-function impairment. *See* Paul H. Lysaker et al., *Patterns of Neurocognitive Deficits and Unawareness of Illness in Schizophrenia*, 191 J. NERVOUS & MENTAL DISEASE 38, 38-39 (2003); *see also* Somaia Mohamed et al., *Insight in Schizophrenia: Its Relationship to Measures of Executive Functions*, 187 J. NERVOUS & MENTAL DISEASE 525, 525 (1999) (finding that unawareness of negative, but not positive, symptoms is associated with executive functioning in individuals with chronic schizophrenia); Kevin D. Morgan & Anthony S. David, *Neuropsychological Studies of Insight in Patients with Psychotic Disorders*, *in* INSIGHT & PSYCHOSIS 2d ed., *supra* note 92, at 177, 189 (summarizing evidence on insight-cognition studies and concluding that the evidence suggests that "good insight is at least partially dependent on intact frontal-executive functioning").

121. *See* Xavier F. Amador et al., *Assessment of Insight in Psychosis*, 150 AM. J. PSYCHIATRY 873 (1993); Amador & Kronengold, *supra* note 107, at 5-13 (describing and comparing insight assessment instruments); Aaron T. Beck et al., *A New Instrument for Measuring Insight: The*

of these scales produce reasonably consistent results,[122] even across national borders and cultural boundaries.[123]

The available evidence uniformly suggests that disordered insight enhances the likelihood of a decision against treatment. A number of studies have found that psychotic patients who are involuntarily hospitalized have significantly lower insight scores than patients who voluntarily enter the hospital for treatment.[124] Similarly, anorectic patients, "[d]espite clear understanding of the benefits of treatment and a wish to recover," often experience "difficulties making a decision to change their behaviour or accept treatment" due to their powerful urge to control a body that seems, to the ill patient, much larger than it really is.[125]

Disordered insight is also associated with treatment noncompliance. Among schizophrenics, for example, a number of studies have found that patients who exhibit deficits in one or another aspect of insight are less likely to be medication-compliant and more likely to require hospitalization.[126] Researchers have found a similar

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*Beck Cognitive Insight Scale*, 68 SCHIZOPHRENIA RES. 319 (2004); Morgan & David, *supra* note 120, at 177, 184-86. *See generally* ESTHER STRAUSS ET AL., A COMPENDIUM OF NEUROPSYCHOLOGICAL TESTS: ADMINISTRATION, NORMS, AND COMMENTARY (3d ed. 2006).

122. *See* M. Sanz et al., *A Comparative Study of Insight Scales and Their Relationship to Psychopathological and Clinical Variables*, 28 PSYCHOLOGICAL MED. 437, 437 (1998). However, the results of self-assessment tools appear to deviate from those produced by clinician-assessment tools when clinician assessment precedes self-assessment. *See* Diana M. Jovanovski et al., *A Comparison Between a Researcher-rated and a Self-report Method of Insight Assessment in Chronic Schizophrenia Revisited: A Replication Study Using the SUMD and SAIQ*, 195 J. NERVOUS & MENTAL DISEASE 165, 166 (2007). Some scales also tend to show correlation between insight and IQ while others do not. *See* Morgan & David, *supra* note 120, at 184.

123. *See* Anthony S. David, *The Clinical Importance of Insight: An Overview*, *in* INSIGHT & PSYCHOSIS 2d ed., *supra* note 92, at 359, 366-67 (summarizing studies).

124. *See id.* at 377-79 (summarizing studies).

125. Jacinta Tan et al., *Competence To Refuse Treatment in Anorexia Nervosa*, 26 INT'L J. L. & PSYCHIATRY 697, 703 (2003) [hereinafter Tan et al., *Competence*].

126. *See* Tania M. Lincoln et al., *Correlates and Long-Term Consequences of Poor Insight in Patients With Schizophrenia: A Systematic Review*, 33 SCHIZOPHRENIA BULL, 324 (Nov. 2007) (reviewing studies); McEvoy, *supra* note 92, at 311, 315-18; *see also* Jennifer C. Day et al., *Attitudes Toward Antipsychotic Medication*, 62 ARCHIVES GEN. PSYCHIATRY 717, 717 (2005); T. Droulot, *Relationships Between Insight and Medication Adherence in Subjects with Psychosis*, 29 ENCEPHALE 430 (2005). The relationship between insight and symptom severity is unclear. One recent meta-analysis of more than forty studies found a "small [but statistically significant] negative relationship between insight and global, positive and negative symptoms," but the symptoms described only 3-7 percent of the variance. Alisa R. Mintz et al., *Insight in Schizophrenia: A Meta-Analysis*, 61 SCHIZOPHRENIA RES. 75, 75 (2003);

correlation between insight and medication compliance among psychotic patients generally.[127] Executive-function deficits that have not evolved into a full-blown insight disorder are also a significant risk factor for harm resulting from self neglect,[128] resistance to medical care, and noncompliance with medication regimes.[129]

Perhaps because poor insight predicts treatment noncompliance, insight is also significantly linked, for many illnesses, with long-term medical prognosis. Insight scores offer a reliable means of predicting which patients with first episodes of many psychotic disorders will relapse and require hospital readmission.[130] Similarly, among patients with eating disorders, greater disturbance in body image is associated with a higher likelihood of post-remission relapse.[131]

Although the research literature is relatively sparse, it appears that restoration of insight frequently alters treatment choices.[132] Psychotic patients who gain insight are more likely to be medication-compliant than those who do not.[133] Researchers studying patients with both psychotic illnesses[134] and eating disorders who

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*see also* Day, *supra*, at 723.

127. *See* M. Nosé et al., *How Often Do Patients with Psychosis Fail To Adhere to Treatment Programmes? A Systematic Review*, 33 PSYCHOL. MED. 1149, 1149 (2003) (reviewing studies and concluding that about one in four psychotic patients is medication nonadherent).

128. *See* Leo M. Cooney et al., *Who Can Stay at Home?: Assessing the Capacity To Choose To Live in the Community*, 164 ARCHIVES INTERNAL MED. 357, 357 (2004); Mary C. Tierney et al., *Neuropsychological Predictors of Self-Neglect in Cognitively Impaired Older People Who Live Alone*, 15 AM. J. GERIATRIC PSYCHIATRY 140, 146 (2007).

129. *See* Schillerstrom et al., *supra* note 112, at 509.

130. *See* David, *supra* note 123, at 378-79 tbl.18.2 (summarizing studies); Richard J. Drake et al., *Insight as a Predictor of the Outcome of First-Episode Nonaffective Psychosis in a Prospective Cohort Study in England*, 68 J. CLINICAL PSYCHIATRY 81, 81 (2007) (finding significant correlation); *see also* Daniela Simon et al., *Depressed Patients' Perceptions of Depression Treatment Decision-Making*, 10 HEALTH EXPECTATIONS 62, 62 (2007) (finding that "lack of insight regarding depression severity substantially delayed patient engagement in treatment seeking and decision-making").

131. *See* Pamela K. Keel et al., *Postremission Predictors of Relapse in Women With Eating Disorders*, 162 AM. J. PSYCHIATRY 2263, 2263 (2005).

132. *See* Sharon Riordan & Martin Humphreys, *Patient Perceptions of Medium Secure Care*, 47 MED. SCI. & L. 20, 20 (2007) (reporting that psychiatric patients in "medium secure" care typically "felt the advantages of hospital care compensated for the disadvantages, particularly as their mental state stabilised and they gained insight into their illness").

133. *See* David, *supra* note 123, at 373-74 (reviewing studies); McEvoy, *supra* note 92, at 326-27 (same).

134. *See* William Gardner et al., *Patients' Revisions of Their Beliefs About the Need for Hospitalization*, 156 AM. J. PSYCHIATRY 1385, 1385 (1999); W. M. Greenberg et al., *Patients'*

were involuntarily hospitalized for treatment have found that "the majority ... later affirmed the necessity of their treatment and showed goodwill toward the treatment process."[135]

Patients with severely impaired insight often pass standard competence tests, however. For example, in one recent study, 57 percent of subjects with diagnosed schizophrenia or schizo-affective disorder passed the "most stringent" version of a widely used, standardized competence test and 92 percent passed the "least stringent" version.[136] In another study which assessed capacity for research participation, fully 80 percent of schizophrenic subjects were deemed competent, under the same standardized test, to consent to a hypothetical drug trial.[137]

At first glance, these results are extremely odd. After all, competence assessment has typically been thought to require assessment of the patient's appreciation of treatment risks and benefits.[138] Indeed, the *Candura* court deemed Mrs. Candura competent to forgo treatment precisely because she had "made it clear that she does not wish to have the operation even though that decision will in all likelihood lead shortly to her death" and there was "no indication in any of the testimony that [Mrs. Candura's decision was not made] ... with full appreciation of the conse-

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*Attitudes Toward Having Been Forcibly Medicated*, 24 BULL. AM. ACAD. PSYCHIATRY & L. 513, 518 (1996) (finding that 60 percent of patients retrospectively thought forced medication was a good idea).

135. Tureka L. Watson et al., *Involuntary Treatment of Eating Disorders*, 157 AM. J. PSYCHIATRY 1806, 1806 (2000); *see also* Terry Carney et al., *Institutional Options in Management of Coercion in Anorexia Treatment: The Antipodean Experiment?*, 26 INT'L J.L. & PSYCHIATRY 647, 650 (2003) (finding that patients involuntarily coerced into treatment may progress at a slower rate, but would not have opted for treatment otherwise); Tan et al., *Competence*, *supra* note 125, at 702-04 (finding that some patients suffering from anorexia nervosa have an appreciation for treatment, but do not wish to undergo treatment).

136. Laura B. Dunn et al., *Prevalence and Correlates of Adequate Performance on a Measure of Abilities Related to Decisional Capacity: Differences Among Three Standards for the MacCAT-CR in Patients with Schizophrenia*, 89 SCHIZOPHRENIA RES. 110, 110 (2007); *see also* Cairns et al., *supra* note 13, at 380 (finding that 56 percent of psychotic inpatients were competent); Jeste et al., *supra* note 13, at 126 (reporting that, in twelve different studies determining the capacity of schizophrenics, 48 to 90 percent of subjects did not have impaired capacity); Palmer et al., *supra* note 13, at 731-32; Zayas et al., *supra* note 13, at 551 (reporting that 93 percent of schizophrenic outpatients passed cognitively-based competence test).

137. *See* David J. Moser et al., *Capacity To Provide Informed Consent for Participation in Schizophrenia and HIV Research*, 159 AM. J. PSYCHIATRY 1201, 1203-04 (2002).

138. *See* Dunn et al., *supra* note 14, at 1323.

quences."[139] Moreover, standardized competence tests do require an inquiry into the patient's understanding of both her condition and the proposed treatment's risks and benefits.[140] For example, the MacArthur Competence Assessment Tool for Treatment (MacCAT-T)—the test actually used in the schizophrenia research described in the last paragraph and in virtually all of the reported studies[141]—requires the patient to "acknowledge[] that he or she manifests the disclosed disorder[] and all or most of the disclosed symptoms" in order to obtain the highest score on the disorder-appreciation scale; similarly, the patient must "acknowledge[] at least some potential for the treatment to produce some benefit" and offer a reason that is "not based on a delusional premise or a serious distortion of reality" in order to obtain a full score on the treatment-appreciation scale.[142]

Given the assessment criteria of the MacCAT-T and the fact that most schizophrenics have significant insight deficits, one would think that evaluators are somehow misusing the MacCAT-T assessment protocols when they pass the vast majority of schizophrenic patients. However, comparative surveys have shown that the MacCAT-T tends to produce highly consistent results when used by different clinicians.[143] Moreover, the researchers who developed the MacCAT-T test report that, in their own research with schizophrenic patients, 78 percent of test takers received full credit on both appreciation scales and 90 percent received full credit on the treatment-appreciation scale.[144] Researchers have also found that subject performance on the MacCAT-T is not significantly correlated with the subject's underlying level of psychopathology.[145] Clearly,

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139. Lane v. Candura, 376 N.E.2d 1232, 1235 (Mass. App. Ct. 1976).

140. Dunn et al., *supra* note 14, at 1323.

141. *Id.* (reviewing range of competence assessment instruments and reporting that the MacArthur scale has "the most empirical support").

142. GRISSO & APPELBAUM, MACCAT-T, *supra* note 14, at 15-16.

143. Ruth Cairns et al., *Reliability of Mental Capacity Assessments in Psychiatric In-Patients*, 187 BRIT. J. PSYCHIATRY 372, 376 (2005).

144. GRISSO & APPELBAUM, MACCAT-T, *supra* note 14, at 31 tbl.3.

145. *But see* Jeffrey A. Kovnick et al., *Competence To Consent to Research Among Long-Stay Inpatients with Chronic Schizophrenia*, 54 PSYCHIATRIC SERVS. 1247, 1247 (2003) (finding that "degree of psychopathology and cognitive functioning were significantly negatively correlated with understanding and appreciation ... [in studied schizophrenic patients and that] [l]ength of hospitalization was significantly negatively correlated with all measures of decision-making capacity"); Scott Stroup et al., *Decision-Making Capacity for Research Participation Among*

something more than misapplication is at work here. It is also important to note that the MacCAT-T does not produce results markedly different from those produced by other competence tests;[146] researchers have reported a very high degree of outcome-correspondence using various standardized competence-assessment tools.[147]

The question remains, however: If 60 to 90 percent of schizophrenic patients fail to comprehend that they are ill, and equivalent numbers fail to attribute one or more symptoms to their illness, how could almost 80 percent sail through the appreciation component of the MacCAT-T (or another standardized competence) test with full credit? There are no published studies analyzing this extraordinarily interesting and important question, but comparison of the MacCAT-T test and the Scale to Assess Unawareness of Mental Disorder (SUMD), the most widely used insight-assessment scale, suggests that the explanation probably lies in varying assessment procedures.

The MacCAT-T assessment is conducted informally based on a brief, nonstandardized interview.[148] The interviewer is directed to "use whatever approach to questioning is comfortable"[149] and to assess appreciation of the underlying disorder based on an inquiry such as this proffered example: "Now that is what your doctors ... think is the problem in your case. If you have any reason to doubt that, I'd like you to tell me so. What do you think?"[150] If the patient "expresses disagreement with the diagnosis or features of the disorder as applied to himself" the clinician is directed to "determine through discussion the basis for the disbelief."[151] But if the patient

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*Individuals in the CATIE Schizophrenia Trial*, 80 SCHIZOPHRENIA RES. 1, 1-2 (2005) (reporting that "in multiple regression models predicting performance on the MacCAT-CR scales, working memory was the only consistent predictor of the components of decision-making capacity").

146. *See* Vanessa Raymont, *The Inter-rater Reliability of Mental Capacity Assessments*, 30 INT'L J.L. & PSYCHIATRY 112, 116 (2007) (finding similar patterns of consistency in the MacCAT-T and the Thinking Rationally About Treatment (TRAT) tests).

147. *Id.* ("[E]xperienced psychiatrists and psychologists are able to make reasonably consistent judgements, despite a heterogenous clinical population with diverse medical disorders.").

148. GRISSO & APPELBAUM, MACCAT-T, *supra* note 14, at 7.

149. *Id.*

150. *Id.*

151. *Id.*

agrees, the test manual requires no further inquiry.[152] Similarly, in assessing treatment-appreciation, the interviewer is directed to determine "whether the patient acknowledges that the proposed treatment *might* be of some benefit and, if not, ... the patient's explanations and reasons for disbelieving that treatment might have some benefit in his or her own situation."[153] The manual notes that the point of this line of questioning "is *not* ... to determine whether the patient is accepting the treatment" but instead to "determine whether the patient is unwilling even to consider (acknowledge the possibility of) the treatment because of confused, delusional, or affective states related to mental disorder."[154]

By contrast, the SUMD involves a semi-structured interview that "evaluates insight as a multidimensional phenomenon" based on a seventy-two-item questionnaire; each item is rated on a five-point scale:[155] "the SUMD allows for the independent assessment of current and retrospective awareness of having a mental disorder, awareness of particular signs and symptoms, benefit from treatment, and the psychosocial consequences of having a mental disorder."[156] Although the SUMD does not rate beliefs about whether treatment is needed, it does provide a "detailed assessment of patients' awareness of, and attribution for, a wide range of signs and symptoms."[157]

It would be useful to have interview transcripts or other detailed comparative accounts to get a fuller comparative picture of the MacCAT-T and SUMD assessment processes, but I could find none in the research literature. However, a recent series of articles does offer a richly textured account of competence assessment in a small group of anorectic patients. Despite the fact that "the majority [of these patients] ... had significant levels of psychopathology" and two "did not fully accept that they suffered from anorexia nervosa despite having good understanding and reasoning,"[158] *all* passed the

152. *Id.*
153. *Id.* at 8.
154. *Id.*
155. Amador & Kronengold, *supra* note 107, at 11.
156. *Id.*
157. *Id.*
158. Tan et al., *Competence*, *supra* note 125, at 701; *see also* Jacinta Tan et al., *Anorexia Nervosa and Personal Identity: The Accounts of Patients and Their Parents*, 26 INT'L J.L. & PSYCHIATRY 533, 538 (2004) [hereinafter Tan et al., *Personal Identity*]; Jacinta Tan et al.,

MacCAT-T at "a high standard ... comparable to [that of a] ... healthy population control group in a previous study using the MacCAT-T."[159] Although the researchers do not provide full transcripts of the competence-assessment interviews, they do offer substantial excerpts.

These excerpts reveal, first of all, that the participants' *knowledge* of their disorder was largely irrelevant to their *feelings* about treatment. This gap between information and emotional response appears to derive from the fact that, for these anorectic patients, their illness had come to represent a core part of their personal identities:

> "It's awful to admit, but in general it's [the anorexia nervosa] the most important thing in my life.... In comparison with relationships, it's much more important than that, with university and work it's a difficult decision, but as it goes I can't say anything but that I did drop my university and that I was in pursuit of thinness at the time. And even now if I were given the opportunity to go back [to university] now but I'd have to be a lot heavier, I'd say no." (Participant C) ....
>
> Interviewer: If your anorexia nervosa magically disappeared, what would be different from right now?
>
> "Everything. My personality would be different. It's been, I know it's been such a big part of me, and—I don't think you can ever get rid of it, or the feelings, you always have a bit in you." (Participant I)
>
> Interviewer: What does being thin achieve for you?
>
> "People would like you more, it's just all I want to be."
>
> Interviewer: So if you achieve that, what kind of person would you be?

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*Control and Compulsory Treatment in Anorexia Nervosa: The Views of Patients and Parents*, 26 INT'L J.L. & PSYCHIATRY 627, 627-43 (2003) [hereinafter Tan et al., *Control*] (finding that those suffering from anorexia nervosa have trouble accepting treatment, even though they understand the consequences of refusing treatment).

159. Tan et al., *Competence*, *supra* note 125, at 704; *see also id.* at 701 ("In the category of 'understanding,' participants had a median score of 6.0 out of a maximum of 6.0. In the category of 'appreciation of illness,' the participants had a median score of 4.0 out of a maximum possible score of 4.0. In the category of 'reasoning,' the participants had a median score of 6.0 out of a maximum of 8.0. These scores reflected the excellent performance of the participants in the MacCAT-T task.").

> "I'd be much happier, and people would like me more." (Participant B).[160]

Identification with their disorder was so powerful that, for some of the interviewees, the risk of dying had become comparatively unimportant: "Although I didn't mind dying, I really didn't want to, it's just I wanted to lose weight, that was the main thing. (Participant I)."[161] Thus, "[d]espite clear understanding of the benefits of treatment and a wish to recover,"[162] some patients were highly ambivalent about their doctors' recommendations:

> "I couldn't stop [dieting]. Don't want to and couldn't anyway." (Participant B)
> "As much as I want to get over it [anorexia nervosa], every time I come to eat I just can't, I think, I dream about when I can go running and I think, if only I could just manage to eat everything, and then I will, but when it comes to it I just can't face it." (Participant H)[163]

In sum, many of these anorectic research subjects had placed their lives and selves in the service of their illness. Although fully aware that they were ill and that the treatment they had been offered could provide medical benefits, they continued to want the distorted experience and opportunities for control that anorexia had given them.

The patients who were interviewed were all in active treatment. Some of them had thus begun to achieve some measure of insight into their situation. For example, one participant told the interviewer:

> "I remember getting some tests back saying how my liver was really damaged and all this, and I thought it was really rather good! *I can't imagine that I thought it*, it felt like really quite an

160. *Id.*; *see also* Tan et al., *Personal Identity*, *supra* note 158, at 539-40 (showing that patients suffering from anorexia nervosa incorporate the disease into their personalities in different ways).

161. Tan et al., *Competence*, *supra* note 125, at 702.

162. *Id.* at 703. The researchers also report that all the study participants were "highly conversant with the facts of their disorder ...." *Id.* at 704.

163. *Id.*

> accomplishment! It was just I'd just done something that I knew hardly anyone else could do." (Participant D)[164]

In a similar vein, another participant was able to recognize and describe the disconnection between her knowledge and her feelings:

> Interviewer: ... So there are two alternatives, really, the treatment package and not having treatment. Which of the two seems the best to you? (4 second silence)
> Interviewer: Which one are you most likely to want? (2 second silence)
> "I'm most likely to want nothing, but I don't think that would help."
> Interviewer: Right, so they are two different questions, which is best and which do you want.
> "Mm." (Agreement)
> Interviewer: So in the end, if I were sitting here and I was your doctor, which would you choose, do you think?
> "Nothing."
> Interviewer: No treatment.
> "No."
> Interviewer: Okay. And which do you actually think is better?
> "The package, the treatment." (Participant I)[165]

Despite these insight gains, the interview data show frequent lapses in accurate self-appraisal. Even though some of the respondent patients were on the road to recovery, their illness continued to exert a powerful, perhaps coercive, grip on their attitudes toward treatment. When such a patient says "no treatment," it thus may be "the anorexia talking" instead of the patient's authentic goals and values.[166]

Although the survey I have just described was small, it reveals a central feature of being anorectic or bulimic: "Anorexia nervosa and bulimia nervosa are united by a distinctive core psychopathology ...; patients overevaluate their shape and weight ...[; they] judge their self-worth largely, or even exclusively, in terms of their shape and

164. *Id.* at 702 (emphasis added).
165. *Id.* at 704.
166. Jacinta Tan, *The Anorexia Talking?*, 362 LANCET 1246, 1246 (2003).

weight and their ability to control them."[167] It is thus likely that the research subjects were typical, and that the MacCAT-T's failure to reveal or take into account the research subjects' distorted body images and lack of insight into those distortions would be replicated in a larger population. Other anorectic patients could also pass the appreciation component of the MacCAT-T, like the research subjects undoubtedly did, simply by not expressing "any reason to doubt" the anorexia diagnosis and admitting that the treatment "might be of some benefit."[168]

Based on their test results and interview data, the authors of the anorexia study concluded that current methods of assessing capacity to refuse treatment were "inadequate to assess the difficulties in treatment decision making many patients diagnosed with anorexia nervosa experience".[169]

> [T]he participants' difficulties ... [in] mak[ing] treatment decisions are poorly captured by the concept of capacity currently in use, which is based on understanding and reasoning. Their difficulties extend beyond this to ... the ability to act in terms of making choices. This ability to act can be affected by the anorexia nervosa itself, which has a strong impact on the patient's sense of needing to be in control of herself and the prospect of losing control when accepting treatment.[170]

Similar issues likely arise in assessing the competence of schizophrenics and other psychotic patients. Just as disordered perception about body size is a diagnostic symptom of eating disorders, disordered experiential perception is a diagnostic symptom of psychotic illness; once afflicted with these distorted perceptions, the "core person" may simply be "eclipsed by symptoms of the

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167. Christopher G. Fairburn & Paul J. Harrison, *Eating Disorders*, 361 LANCET 407, 407 (2003).

168. GRISSO & APPELBAUM, MACCAT-T, *supra* note 14, at 7-8.

169. Tan et al., *Competence*, *supra* note 125, at 699.

170. Tan et al., *Control*, *supra* note 158, at 642; *see also* Tan, *The Anorexia Talking?*, *supra* note 166, at 1246 (concluding that for anorectic patients, "the paramount importance of being thin ... devalue[s] other aspects of her life, such as relationships, education, and even life itself. This new value system [may lead the patient to] ... decide that the risk of death is preferable to the prospect of gaining weight.").

disease."[171] However, like the anorectic patients who passed the MacCAT-T with flying colors, mentally ill patients whose values have been eclipsed by their illness may not express "any reason to doubt" their diagnosis and may admit that the treatment "might be of some benefit."[172]

Consider the case of Ian Chovil, who has described on his website many years of living with schizophrenia. Chovil says that his first symptoms appeared during adolescence, and that he "was quite strange from 16-25 ...[, but nonetheless] graduated [from college] with [honors]."[173] After a brief hospitalization, Chovil began to suffer from paranoid delusions. He was confident that "the CIA was after [him] ... [and] Tibetan [B]uddhist lamas were reading [his] mind everywhere [he] went."[174] Chovil gradually "los[t] contact with reality," but he "never told anyone what was happening."[175] Chovil did not obtain psychiatric help until he was arrested and a judge "realized [he] was a psychiatric case" and placed him on probation for three years with a requirement that he see a psychiatrist during that period.[176] Chovil went to his appointments to stay out of jail, but revealed nothing about his delusions: "Psychiatrists are only human ..., while I was almost alien and they wouldn't have understood what was happening so I never told them anything."[177] Some time later, during treatment for alcoholism, Chovil finally did begin "a maintenance dose of anti-psychotics," but even with this aid, he reports that "[i]t took several years to completely believe and understand that I had schizophrenia."[178]

Chovil describes the same pattern of personal investment in illness that seems to beset anorectic patients. Schizophrenics, he reports from personal experience,

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171. XAVIER AMADOR, I AM NOT SICK, I DON'T NEED HELP 147 (2d ed. 2007).

172. GRISSO & APPELBAUM, MACCAT-T, *supra* note 14, at 7-8.

173. Ian Chovil, The Experience of Schizophrenia, A Brief History, http://www.chovil.com/story.html (last visited Nov. 30, 2007).

174. *Id.*

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*; *see also* Frederick J. Frese III, *Inside "Insight"—A Personal Perspective on Insight in Psychosis*, *in* INSIGHT & PSYCHOSIS 2d ed., *supra* note 92, at 356-57.

> may find it very difficult to lose their trust in these special processes they are experiencing.... The process of losing trust in something you have come to believe that is much more powerful than you and especially interested in you is very painful, and usually means very significant personal losses. Delusions and hallucinations support you in the belief that you are very special, and that powerful forces know you are very special, and even on medication individuals will be very reluctant to give that up.[179]

Fueled by these perceived benefits and underlying neuroanatomic features of their disease, insight deficits in psychotic patients may persist for years, just as they did in Chovil's case.[180]

The evidence suggests that disordered insight may affect large numbers of treatment decisions. In the United States alone, experts estimate that there are six million individuals with serious mental illnesses, half of whom do not believe they are ill and thus refuse to follow through on treatment recommendations.[181] Insight deficiencies are also a core symptom of dementia, and "[m]ore than five million Americans have Alzheimer's Disease [alone], a ten percent increase from the last official tally five years ago."[182] Insight deficits are also common symptoms of substance abuse; they may occur in victims of stroke and vascular accidents as well as brain injury.[183]

Of course, patients may fail to comply with treatment recommendations or make decisions against treatment for reasons unrelated to an insight disorder. We cannot simply assume, when a patient who is suffering from a malady that causes disordered insight acts against her medical interests, that it is the illness talking instead of the patient. But if the patient has been medically assessed and found to be afflicted with severely disordered insight, then it is reasonable to assume that it is the coercive influence of illness, and not the patient's authentic goals and values, that lead the patient to favor continuation of her disease over her life and health.

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179. Ian Chovil, Compliance, http://www.chovil.com/compliance.html (last visited Nov. 30, 2007).

180. *See* AMADOR, *supra* note 171, at 145-48 (recounting cases anecdotally).

181. *See id.* at 5.

182. Jane Gross, *Prevalence of Alzheimer's Rises 10% in Five Years*, N.Y. TIMES, Mar. 21, 2007, at A1.

183. *See supra* notes 104-06 and accompanying text.

*2. Depression and Hopelessness*

Depression is a debilitating illness that impairs the health and lives of its victims. Depression predicts future illness and premature death.[184] It distorts thought and experience.[185] It interferes with virtually every aspect of daily life.[186]

A rapidly growing body of research evidence also shows that depression alters treatment preferences. A number of researchers have studied patients' desires for "hastened death" in relation to observable patient characteristics. Virtually all have reported a strong correlation between major depression and such a desire.[187] In an early study, Harvey Chochinov and others found that, among a group of terminally ill patients, those who were deeply depressed were seven times more likely (58.8 percent versus 7.7 percent) to

184. *See* Linda Ganzini et al., *Depression and Mortality in Medically Ill Older Adults*, 45 J. AM. GERIATRIC SOC'Y 307, 310 (1997) (reporting that, among a group of medically but not terminally ill older veterans, diagnosed depression significantly predicted survival thirty months later); Stephen Kisely et al., *Mortality in Individuals Who Have Had Psychiatric Treatment: Population-Based Study in Nova Scotia*, 187 BRITISH J. PSYCHIATRY 552, 554 (2005) (explaining that depression increased mortality rates across the population); Lea C. Watson et al., *Depression in Assisted Living: Results from a Four-State Study*, 11 AM. J. GERIATRIC PSYCHIATRY 534, 539-40 (2003) (reporting that severely depressed residents of long-term care facilities had a statistically significant increased rate of death and that depression was significantly associated with medical comorbidity, social withdrawal, psychosis, agitation, and length of residence in the facility, and finding that depressed residents were discharged to nursing homes at 1.5 times the rate of nondepressed residents); *Depression and Heart Disease*, HARV. HEART LETTER, Apr. 2001, at 1, 3-4 (reporting, for every five-point increase in individual depression scores, a 15 percent increase in heart disease and a 16 percent increase in mortality). *See generally* Kim T.J.L. Ensinck et al., *Is There an Increased Risk of Dying After Depression?*, 156 AM. J. EPIDEMIOLOGY 1043 (2002).

185. For a moving account of depression's impact, *see generally* WILLIAM STYRON, A DARKNESS VISIBLE: A MEMOIR OF MADNESS (1990).

186. *See* Polly Hitchcock Noël et al., *Depression and Comorbid Illness in Elderly Primary Care Patients: Impact on Multiple Domains of Health Status and Well-Being*, 2 ANNALS FAM. MED. 555, 559 (2004) (reporting that depression severity was significantly associated with four different indicators of general health after controlling for sociodemographic differences, other psychological dysfunction, and the presence of eleven chronic medical conditions; although study participants had an average of 3.8 chronic medical illnesses, depression severity made a larger independent contribution than medical comorbidities to three of four health indicators).

187. Major depression is generally defined as depressed mood or loss of interest in nearly all activities for at least two weeks accompanied by at least five psychological or somatic symptoms associated with depression. *See* John W. Williams, Jr. et al., *Is This Patient Clinically Depressed?*, 287 J. AM. MED. ASS'N 1160, 1161 tbl.1 (2002) (citing DSM-IV).

express a "serious and pervasive desire to die" than those who were not depressed.[188] More recently, William Breitbart and colleagues found that terminally ill cancer patients with symptoms of major depression were four times more likely than patients without such symptoms (47 percent versus 12 percent) to demonstrate "a high desire for hastened death."[189] A large number of other U.S. surveys have produced results similar to the Chochinov and Breitbart findings.[190]

The correlation between depression and a desire for hastened death is not unique to the United States. Researchers have reported

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188. *See* Harvey M. Chochinov et al., *Desire for Death in the Terminally Ill*, 152 AM. J. PSYCHIATRY 1185, 1187-88 (1995).

189. *See* William Breitbart et al., *Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer*, 284 J. AM. MED. ASS'N 2907, 2910 (2000).

190. *See* M.A. Achille & J.R. Ogloff, *Attitudes Toward and Desire for Assisted Suicide Among Persons with Amyotrophic Lateral Sclerosis*, 48 OMEGA 1 (2003-04) (finding that willingness to contemplate assisted suicide was associated with reports of elevated levels of depressive symptoms and reports of hopelessness); William Breitbart et al., *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 AM. J. PSYCHIATRY 238, 241 (1996) (reporting that HIV-infected patients' interest in physician-assisted suicide appeared to be more a function of psychological distress and social factors than physical factors); Ezekiel J. Emanuel et al., *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, 284 J. AM. MED. ASS'N 2460, 2460 (2000) (reporting that, among a group of 988 terminally ill patients, factors associated with being more likely to consider euthanasia or PAS were depressive symptoms, substantial caregiving needs, and pain, and that patients with depressive symptoms and dyspnea were more likely to change their minds to consider euthanasia or PAS than others); Kathleen Guentner, *Preferences for Mechanical Ventilation Among Survivors of Prolonged Mechanical Ventilation and Tracheostomy*, 15 AM. J. CRITICAL CARE 65, 72, 74 (2006) (reporting that patients who would not have chosen mechanical ventilation had more depressive symptoms and were more likely to be insured by Medicare); Colleen S. McClain et al., *Effect of Spiritual Well-Being on End-of-Life Despair in Terminally-Ill Cancer Patients*, 361 LANCET 1603, 1603 (2003) (reporting that "depression was highly correlated with desire for hastened death in participants low in spiritual well-being, but not in those high in spiritual well-being"); Diane E. Meier et al., *Characteristics of Patients Requesting and Receiving Physician-Assisted Death*, 163 ARCHIVES INTERNAL MED. 1537, 1538 (2003) (reporting that nearly half of terminally ill patients who requested physician-assisted death were depressed at the time of the request); *see also* Linda Ganzini et al., *Attitudes of Patients with Amyotrophic Lateral Sclerosis and Their Caregivers Toward Assisted Suicide*, 339 NEW ENG. J. MED. 967, 971 (1998); Barry Rosenfeld et al., *Measuring Desire for Death Among Patients with HIV/AIDS: The Schedule of Attitudes Toward Hastened Death*, 156 AM. J. PSYCHIATRY 94, 98 (1999); Kenneth E. Rosenfeld et al., *Factors Associated with Change in Resuscitation Preference of Seriously Ill Patients*, 156 ARCHIVES INTERNAL MED. 1558, 1564 (1996); Keith G. Wilson et al., *Attitudes of Terminally Ill Patients Toward Euthanasia and Physician-Assisted Suicide*, 160 ARCHIVES INTERNAL MED. 2454, 2458-59 (2000).

similar results in Australia,[191] Greece,[192] Ireland,[193] Japan,[194] and the Netherlands.[195] The evidence thus suggests that depression influences treatment choices independently of the cultural context in which that choice is made. Despite occasional reports finding no correlation between depression and interest in hastened death,[196] experts on end-of-life care have concluded that "for seriously ill hospitalized patients, depressive mood plays a substantial role in a patient's refusal of life-sustaining care ...."[197] Indeed, some have urged that "strong consideration—or a low threshold—for a psychiatric evaluation should be given when a patient expresses interest in euthanasia or PAS."[198]

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191. B. Kelly et al., *Factors Associated with the Wish To Hasten Death: A Study of Patients with Terminal Illness*, 33 PSYCHOL. MED. 75, 75, 79 (2003) (reporting that higher levels of depressive symptoms, being admitted to an inpatient hospice, greater perception of being a burden, lower family cohesion, lower social support, higher anxiety, and greater physical symptoms were all related to a high interest in hastened death in a sample of terminally ill cancer patients); David W. Kissane et al., *Seven Deaths in Darwin: Case Studies Under the Rights of the Terminally Ill Act, Northern Territory, Australia*, 352 LANCET 1097, 1098, 1101 (1998).

192. *See* Kyriaki Mystakidou et al., *Desire for Death Near the End of Life: The Role of Depression, Anxiety and Pain*, 27 GEN. HOSP. PSYCHIATRY 256, 256 (2005) (reporting that HADS-Depression scale, HADS-Anxiety scale, and interaction between HADS-Depression and opioids were significant predictors of Schedule of Attitudes Toward Hastened Death (G-SAHD) scores); *see also* Kyriaki Mystakidou et al., *The Role of Physical and Psychological Symptoms in Desire for Death: A Study of Terminally Ill Cancer Patients*, 15 PSYCHO-ONCOLOGY 355, 355, 358 (2005).

193. *See* Eoin Tiernan et al., *Relations Between Desire for Early Death, Depressive Symptoms, and Antidepressant Prescribing in Terminally Ill Patients with Cancer*, 95 J. ROYAL SOC. MED. 386, 387, 389-90 (2002) (reporting that desire for early death was significantly correlated with depression scores).

194. *See* Tatsuo Akechi et al., *Suicidality in Terminally Ill Japanese Patients with Cancer*, 100 CANCER 183, 188 (2004) (reporting that self-reported anxiety and depression were significantly associated with suicidal ideation among terminally ill cancer patients).

195. *See* Marije L. van der Lee et al., *Euthanasia and Depression: A Prospective Cohort Study Among Terminally Ill Cancer Patients*, 23 J. CLINICAL ONCOLOGY 6607, 6609-11 (2005) (finding, in a group of terminally ill cancer patients with a life expectancy of three months or less, that the risk to requesting euthanasia was 4.1 times higher among patients with depressed mood than among patients without depressed mood).

196. *See* Lewis M. Cohen et al., *Depression and Suicidal Ideation in Patients Who Discontinue the Life-Support Treatment of Dialysis*, 64 PSYCHOSOMATIC MED. 889, 892-93 (2002); A. Srikumar Menon et al., *Depression, Hopelessness, and the Desire for Life-Saving Treatments Among Elderly Medically Ill Veterans*, 8 AM. J. GERIATRIC PSYCHIATRY 333, 339-40 (2000).

197. K. Rosenfeld et al., *supra* note 190, at 1564.

198. Ezekiel J. Emanuel, *Depression, Euthanasia, and Improving End-of-Life Care*, 23 J. CLINICAL ONCOLOGY 6456, 6457 (2005).

The research evidence also shows that the link between depression and the desire for hastened death is not confined to the terminally ill. Karen Blank and colleagues found that 15 percent of ill, hospitalized patients who were depressed said that they desired physician-assisted death, compared to only 1.1 percent of those who did not suffer from depression.[199] Another group of researchers who studied the resuscitation preferences of patients with COPD, a severe, life-threatening respiratory condition, found that "health-related quality of life" was not significantly associated with those preferences, but that depression was; only 23 percent of patients without depression said that they would refuse resuscitation treatment, compared to 50 percent of those with depression.[200] Among Alzheimer's Disease patients, depression, but not cognitive impairment, is significantly correlated with interest in hastened death.[201] And in community surveys of the elderly, desire for death is significantly correlated with depressive symptoms.[202]

The research evidence also shows that depression's impact on medical choice is not confined to decisions, like treatment refusal and physician-assisted suicide, that will clearly hasten death. Patients who are depressed are significantly less compliant with medication and treatment recommendations; researchers have

199. Karen Blank et al., *Life-Sustaining Treatment and Assisted Death Choices in Depressed Older Patients*, 49 J. AM. GERIATRIC SOC'Y 153, 155-56, 158 (2001); *see also* Ajit Shah et al., *Suicidal Ideation in Acutely Medically Ill Elderly Inpatients: Prevalence, Correlates and Longitudinal Stability*, 15 INT'L J. GERIATRIC PSYCHIATRY 162, 166-67 (2000) (reporting a significant correlation between suicidality scores and depression scores in population of medically ill elderly hospital patients).

200. *See* Renee D. Stapleton et al., *Association of Depression and Life-Sustaining Treatment Preferences in Patients with COPD*, 127 CHEST 328, 329, 331 (2005). However, depression was not significantly associated with preferences for mechanical ventilation. *Id.* at 331.

201. *See* Brian Draper et al., *Suicidal Ideation and the 'Wish to Die' in Dementia Patients: The Role of Depression*, 27 AGE & AGEING 503 (1998).

202. *See* Michael E. Dewey et al., *Expressed Wish To Die and Mortality in Older People: A Community Replication*, 22 AGE & AGEING 109 (1993); A.F. Jorm et al., *Factors Associated with the Wish To Die in Elderly People*, 24 AGE & AGEING 389, 391 (1995).

found that depressed patients with AIDS,[203] asthma,[204] diabetes,[205] and heart disease[206] are all less likely to follow their doctors' advice. Indeed, one meta-analysis of twenty different studies concluded that "the odds are 3 times greater that depressed patients will be noncompliant with medical treatment recommendations."[207]

Finally, the research evidence shows that treatment for depression often alters patients' medical choices. One group of researchers assessed severely ill patients' resuscitation preferences at six-month intervals. For patients whose depression scores improved by at least one point between assessments, the adjusted probability of a change in preference that favored resuscitation was 44 percent; for patients whose depression scores worsened by at least one point, this probability was only 8 percent: "In other words, for the one fifth of patients with substantial changes in depression scores between interviews, there was a greater than 5-fold difference in likelihood of changing preference depending on direction of mood change ...."[208] Another group of researchers treated a small group of terminally ill,

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203. *See* Adriana Ammassari et al., *Depressive Symptoms, Neurocognitive Impairment, and Adherence to Highly Active Antiretroviral Therapy Among HIV-Infected Persons*, 45 PSYCHOSOMATICS 394, 395, 398-99 (2004).

204. *See* Melissa Opolski & Ian Wilson, *Asthma and Depression: A Pragmatic Review of the Literature and Recommendations for Future Research*, 1 CLINICAL PRAC. & EPIDEMIOLOGY MENTAL HEALTH 18, 20-21 (2005).

205. *See* Iftekhar D. Kalsekar et al., *Depression in Patients with Type 2 Diabetes: Impact on Adherence to Oral Hypoglycemic Agents*, 40 ANNALS PHARMACOTHERAPY 605, 605-06 (2006); Amy M. Kilbourne et al., *How Does Depression Influence Diabetes Medication Adherence in Older Patients?*, 13 AM. J. GERIATRIC PSYCHIATRY 202, 202-03, 207 (2005); Elizabeth H.B. Lin et al., *Relationship of Depression and Diabetes Self-Care, Medication Adherence, and Preventive Care*, 27 DIABETES CARE 2154, 2156-57 (2004); Patrick J. Lustman et al., *Depression and Poor Glycemic Control*, 23 DIABETES CARE 934, 940 (2000).

206. *See* Anil Gehi et al., *Depression and Medication Adherence in Outpatients with Coronary Heart Disease: Findings from the Heart and Soul Study*, 165 ARCHIVES INTERNAL MED. 2508, 2511 (2005); Martje H.L. van der Wal et al., *Compliance in Heart Failure Patients: The Importance of Knowledge and Beliefs*, 27 EUR. HEART J. 434, 436-37 (2006).

207. M. Robin DiMatteo et al., *Depression Is a Risk Factor for Noncompliance with Medical Treatment: Meta-Analysis of the Effects of Anxiety and Depression on Patient Adherence*, 160 ARCHIVES INTERNAL MED. 2101, 2101 (2000) (reviewing studies); *see also* Isabella Jenkins et al., *Relationship of Psychiatric Diagnosis and Weight Loss Maintenance in Obese Breast Cancer Survivors*, 11 OBESITY RES. 1369, 1373 (2003). In one study, even symptoms of *maternal* depression "were associated with a constellation of beliefs and attitudes that may significantly influence adherence to [children's] asthma medications and illness." Susan J. Bartlett et al., *Maternal Depressive Symptoms and Adherence to Therapy in Inner-City Children with Asthma*, 113 PEDIATRICS 229, 229 (2004).

208. K. Rosenfeld et al., *supra* note 190, at 1561.

suicidal cancer patients for major depression; after one week of treatment, "five of the six patients showed a marked improvement in their mood and showed no further suicidal thoughts or requests for terminal sedation."[209] Among diabetics, "relief of depression is associated with improved glycemic control."[210] Adherence to prescribed treatment for depression is associated with significantly increased adherence to prescribed treatments for other illnesses.[211]

If depression is strongly associated with particular medical choices and treatment for depression tends to alter those choices, then it seems likely that many of the medical decisions made by depressed patients are not authentic, autonomous choices. Instead, it seems likely that depression acts as a coercive influence that interferes with the patient's capacity to recognize her genuine treatment preferences.

The research evidence shows that depression does not typically coerce treatment preferences by interfering with the capacity to communicate, understand risk-related information, and rationally process information, however. The vast majority of depressed patients thus can pass standard competence tests. For example,

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209. *See* Akira Kugaya et al., *Successful Antidepressant Treatment for Five Terminally Ill Cancer Patients with Major Depression, Suicidal Ideation and a Desire for Death*, 6 SUPPORTIVE CANCER CARE 432, 432 (1999); *see also* Linda Ganzini et al., *The Effect of Depression Treatment on Elderly Patients' Preferences for Life-Sustaining Treatment*, 151 AM. J. PSYCHIATRY 1631, 1635, 1636 (1995) (explaining that remission of depression resulted in an increase in desire for life-sustaining medical therapy in subjects who had been initially rated as more severely depressed, more hopeless, and more likely to overestimate the risks and to underestimate the benefits of treatment, but not in those suffering from milder depression); Stuart C. Hooper et al., *Major Depression and Refusal of Life-Sustaining Medical Treatment in the Elderly*, 165 MED. J. AUSTL. 416, 418 (1996); Melinda Lee & Linda Ganzini, *The Effect of Recovery from Depression on Preferences for Life-Sustaining Therapy in Older Patients*, 49 J. GERONTOLOGY M15, M15 (1994) (finding that treatment of mild to moderate depression did not alter treatment preferences); Sean O'Mahony et al., *Desire for Hastened Death, Cancer Pain and Depression: Report of a Longitudinal Observational Study*, 29 J. PAIN & SYMPTOM MGMT. 446, 447 (2005) (reporting that "improvement in depression moderated the severity of desire for hastened death in a population of patients with cancer pain ... [while] [i]mprovement[] in functional impairment due to pain did not ...").

210. *See* Ryan J. Anderson et al., *The Prevalence of Comorbid Depression in Adults with Diabetes: A Meta-Analysis*, 24 DIABETES CARE 1069, 1069 (2001) (reviewing studies); *see also* Lustman et al., *supra* note 205 (reviewing twenty-four studies examining the relationship between depression and glycemic control and concluding that depression was a highly significant correlate of hyperglycemia, the result of failure to control glycemic levels).

211. *See* DiMatteo, *supra* note 207 (reviewing studies); Wayne Katon et al., *Impact of Antidepressant Drug Adherence on Comorbid Medication Use and Resource Utilization*, 165 ARCHIVES INTERNAL MED. 2497, 2497 (2005) (reviewing studies).

among ninety-two clinically depressed survey participants who took the MacCAT-T, only 12 percent scored in the "impaired" range on "appreciation," 5 percent on "understanding," and 8 percent on "reasoning."[212] In another survey, "[a]lmost all [clinically depressed] subjects performed quite well on the capacity measures and maintained that level of performance over time. There was no correlation between performance and degree of depressive symptoms ...."[213]

Experts thus suggest that depression's impact on health-care decision making is irrational and that several different pathways may be involved:

> [One] depressed patient, convinced that his situation will never change, may refuse treatment based on the unrealistic belief that it will not help him.... [A] slightly different sort of depressed patient ... [may] not [be] motivated to take ... risks into account in the same way as the rest of us.... [And s]ome patients, as a result of their depression, may even want to take risks. Roth et al wonder about the competence of one such patient, a 49-year-old woman capable of fully understanding the electroconvulsive therapy for which she was being asked to consent, but who, when told that electroconvulsive therapy carried a 1 in 3000 chance of death, replied, "I hope I am the one."[214]

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212. *See* Berg et al., *supra* note 10, at 372 n.91.

213. Paul S. Appelbaum et al., *Competence of Depressed Patients for Consent To Research*, 156 AM. J. PSYCHIATRY 1380, 1380 (1999).

214. Carl Elliott, *Caring About Risks: Are Severely Depressed Patients Competent to Consent To Research?*, 54 ARCHIVES GEN. PSYCHIATRY 113 (1997); *see also* Harold J. Bursztajn et al., *Beyond Cognition: The Role of Disordered Affective States in Impairing Competence To Consent to Treatment*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 383, 383 (1991) (finding that "patients with major affective disorders can retain the cognitive capacity to *understand* the risks and benefits of a medication, yet fail to *appreciate* its benefits"); Grimes et al., *supra* note 113, at 1564 (reporting that "[v]oluntariness also may be diminished by apathy, as when patients with depression feel hopeless and do not care what is done to them. Some patients may even make choices contrary to their values and 'nondepressed' desires, out of a feeling that they are guilty and deserve punishment."); Mark D. Sullivan & Stuart J. Youngner, *Depression, Competence, and the Right To Refuse Lifesaving Medical Treatment*, 151 AM. J. PSYCHIATRY 971, 971 (1994).

Depression alters the context in which decisions are made: it can magnify pain,[215] impair coping capacity,[216] and contribute to the loss of functional ability.[217]

Depression can also induce feelings of hopelessness. Indeed, "hopelessness is [now] widely recognized to be a cardinal symptom of major depression,"[218] and in elderly patients it may be a more reliable indicator of major depressive illness than depressed mood. Hopelessness is a powerful predictor of suicide; in one prospective study of psychiatric outpatients, a score of nine or higher on the Beck Hopelessness Scale identified sixteen (94.2 percent) of the seventeen patients who eventually committed suicide.[219] Hopelessness is also a powerful predictor of interest in hastened death. In a survey of older, medically ill patients in the care of a Veterans Administration hospital, "[s]ubjects with high levels of hopelessness ... were at least five times more likely to refuse CPR if required during the[ir] current hospitalization."[220] Another group of researchers found that:

> Among patients who were neither depressed nor hopeless, none had a high desire for hastened death, whereas approximately one fourth of the patients with either of one of these factors had a high desire for hastened death, and nearly two-thirds of

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215. *See* G. Magni et al., *Prospective Study on the Relationship Between Depressive Symptoms and Chronic Musculoskeletal Pain*, 56 PAIN 289, 294-96 (1994).

216. *See* C. Dickens & F. Creed, *The Burden of Depression in Patients with Rheumatoid Arthritis*, 40 RHEUMATOLOGY 1327, 1327-28 (2001).

217. *See* P.P. Katz & E.H. Yelin, *Prevalence and Correlates of Depressive Symptoms Among Persons with Rheumatoid Arthritis*, 20 J. RHEUMATOLOGY 790, 794-95 (1993); Daniel Weintraub et al., *Effect of Psychiatric and Other Nonmotor Symptoms on Disability in Parkinson's Disease*, 52 J. AM. GERIATRICS SOC'Y 784, 784 (2004); *see also* N.J. Rubin, *Severe Asthma and Depression*, 2 ARCHIVES FAM. MED. 26 (1993) (reporting that asthma and depression "are thought to interact to worsen both conditions, especially at the severe end of the spectrum of disease").

218. Mark D. Sullivan, *Hope and Hopelessness at the End of Life*, 11 AM. J. GERIATRIC PSYCHIATRY 393, 396 (2003); *see also* Harvey Max Chochinov, *Dying, Dignity, and New Horizons in Palliative, End-of-Life Care*, 56 CA 84, 84 (2006).

219. *See* Aaron T. Beck et al., *Relationship Between Hopelessness and Ultimate Suicide: A Replication with Psychiatric Outpatients*, 147 AM. J. PSYCHIATRY 190, 190 (1990). Similar results have been obtained with psychiatric inpatients. *See* Aaron T. Beck et al., *Hopelessness and Eventual Suicide: A 10-Year Prospective Study of Patients Hospitalized with Suicidal Ideation*, 142 AM. J. PSYCHIATRY 559, 561 (1985).

220. *See* Menon et al., *supra* note 196, at 333.

> patients with both depression and hopelessness had high desire for hastened death.[221]

And although one might expect that severe illness would often produce hopelessness, neither disease severity nor prognosis are useful predictors of hopelessness and suicidal ideation.[222]

In sum, major depression has the capacity to dramatically diminish the quality of daily life and to plunge its victim into a hopeless state in which he loses all faith in the future. Depression's effects may be irrational, but they are nonetheless real and, for some patients, they appear to overcome the desire for life and health and to coerce decisions against the patient's medical interests.

Large numbers of patient choices may be affected by depression's strong but irrational grip. Surveys show that perhaps one-quarter of patients with type 2 diabetes,[223] 13-20 percent of those with rheumatoid arthritis,[224] 13 percent of those in assisted living facilities,[225] a third of those with diagnosed Alzheimer's Disease,[226]

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221. Breitbart et al., *supra* note 189, at 2910; *see also* Harvey Max Chochinov et al., *Depression, Hopelessness, and Suicidal Ideation in the Terminally Ill*, 39 PSYCHOSOMATICS 366, 366 (1998) (finding that among a group of terminally ill cancer patients, hopelessness was a better predictor of suicidal ideation than depression); Ganzini et al., *supra* note 190, at 967; Wilson et al., *supra* note 190, at 2454.

222. *See* M. Lloyd-Williams & T. Friedman, *Depression in Palliative Care Patients—A Prospective Study*, 10 EUR. J. CANCER CARE 270, 270 (2001) (finding, among patients receiving palliative care only for advanced metastatic cancer, that the incidence of depression according to International Classification of Diseases criteria was 22 percent); Stefan C. Weiss, *Understanding the Experience of Pain in Terminally Ill Patients*, 357 LANCET 1311, 1312 (2001) (finding that 17 percent of all surveyed terminally ill patients and 22 percent of those in pain were clinically depressed); *see also* Chochinov et al., *supra* note 221; Sullivan, *supra* note 218.

223. *See* Thaddeus J. Kuszmar et al., *Suicide and Prevention in High-Risk Hospitalized Populations*, 25 PHYSICIAN ASSISTANT 21 (2001).

224. *See* Dickens & Creed, *supra* note 216, at 1327.

225. *See* Watson et al., *supra* note 184, at 534 (using the Cornell Scale for Depression in Dementia (CSDD), 13 percent of surveyed residents were depressed and more than "one-third of residents had symptoms of depression, such as anxious expression, rumination, or worrying, and 25% displayed sad voice, sad expression, or tearfulness"); *see also* Harold G. Koenig et al., *Major Depressive Disorder in Hospitalized Medically Ill Patients: An Examination of Young and Elderly Male Veterans*, 39 J. AM. GERIATRICS SOC'Y 881, 886 (1991) (reporting major depressive disorder in 22 percent of medically ill, hospitalized male veterans under forty and 13 percent of those seventy or over).

226. *See* George S. Zubenko et al., *A Collaborative Study of the Emergence and Clinical Features of the Major Depressive Syndrome of Alzheimer's Disease*, 160 AM. J. PSYCHIATRY 857, 857, 860 (2003) (reporting "common emergence in the early stages of dementia when

and more than 60 percent of those recovering from a stroke,[227] are depressed. Just as depression increases the risk that an illness will be experienced as particularly severe and debilitating, the challenges and stress of a chronic illness increase the risk of both depression[228] and suicidality.[229]

Moreover, although the efficacy of treatment for depression has been shown again and again,[230] substantial numbers of patients with clinically detectible moderate or severe depression are not accurately diagnosed and thus do not obtain appropriate medications. For example, in one survey of cancer patients, only 40 percent of patients with moderate or severe depression were receiving antidepressants.[231] In another survey of patients in long-term care facilities, only 18 percent of those determined to be depressed were receiving medication.[232] And as many as two-thirds of the patients

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symptoms of cognitive impairment are least likely to contribute to the syndromal diagnosis of major depression" and suggesting high prevalence of depression in patients with other forms of dementia).

227. *See* P. Angelelli et al., *Development of Neuropsychiatric Symptoms in Poststroke Patients: A Cross-Sectional Study*, 110 ACTA PSYCHIATRICA SCANDINAVIAN 55, 55 (2004) (reporting that 61 percent of a post-stroke population were depressed and that greater depression "evolved in the year following stroke").

228. *See* Linnea Haarasilta et al., *Major Depressive Episode and Physical Health in Adolescents and Young Adults: Results from a Population-Based Inverview Survey*, 15 EUR. J. PUB. HEALTH 489, 489 (2005); Deborah J. Wexler, *Low Risk of Depression in Diabetes? Would That It Were So*, 175 CAN. J. MED. 47, 47-48 (2006).

229. *See* Benjamin Druss & Harold Pincus, *Suicidal Ideation and Suicide Attempts in General Medical Illnesses*, 160 ARCHIVES INTERNAL MED. 1522, 1522 (2000) (reporting that in a large national survey, 16.3 percent of all respondents, 25.2 percent of those with a general medical condition, and 35 percent of those with two or more medical illnesses reported lifetime suicidal ideation; 5.5 percent of all respondents, 8.9 percent of those with a general medical illness, and 16.2 percent of those with two or more medical conditions reported a suicide attempt. "Cancer and asthma were each associated with a more than 4-fold increase in the likelihood of a suicide attempt."); Bruce L. Rollman & M. Katherine Shear, *Depression and Medical Comorbidity: Red Flags for Current Suicidal Ideation in Primary Care*, 65 PSYCHOSOMATIC MED. 506, 506-07 (2003) (summarizing data); *see also* Stephen E. Bartels et al., *Suicidal and Death Ideation in Older Primary Care Patients with Depression, Anxiety, and At-Risk Alcohol Use*, 10 AM. J. GERIATRIC PSYCHIATRY 417, 417 (2002).

230. *See, e.g.*, Linda H. Harpole et al., *Improving Depression Outcomes in Older Adults with Comorbid Medical Illness*, 27 GEN. HOSP. PSYCHIATRY 4, 4 (2005) (finding, among a large sample of depressed patients suffering from an average of 3.8 chronic medical conditions, that "the number of chronic diseases did not affect the likelihood of response to ... intervention," and "[i]ntervention patients experienced significantly lower depression during all follow-up time points ...").

231. *See* O'Mahony et al., *supra* note 209, at 446.

232. *See* Watson et al., *supra* note 184, at 534.

who commit suicide—the vast majority of whom are thought to be severely depressed—have seen a physician in the month before their deaths.[233]

Of course, the wish for hastened death, treatment noncompliance, and decisions against treatment may arise independently of depression. We cannot assume that every patient who makes a decision against her medical interests is depressed or that treatment for depression will invariably change the patient's mind.[234] However, we can assume that untreated major depression poses a very high risk of unduly influencing treatment preferences and rendering them inauthentic.

## III. A NEW APPROACH TO MEDICAL DECISION MAKING: ASSESSING COMPETENCE *PLUS* COERCION

### *A. The Law of Wills as a Model for Reform*

The evidence shows that patients suffering from major depression or disordered insight frequently make treatment choices that pose serious risks to life and health. The evidence also shows that these risky treatment choices are typically involuntary; they represent the coercive influence of illness instead of the goals and values of the patient herself. Once the coercive influence of illness has been removed, patients rarely ratify decisions against their medical interests. Instead, they express relief that medical professionals refused to heed the voice of their disease.

Legal standards for assessing patient competence are inadequate to reveal the coercive influence of depression and disordered insight. Because these standards assess only the patient's knowledge of

233. *See* Rollman & Shear, *supra* note 229, at 506; *see also* Simeon Margolis & Karen L. Swartz, *Depression and Anxiety* (Johns Hopkins White Papers 2000) ("50 to 70% of U.S. suicides are due to depression, and 15% of severely depressed people commit suicide.").

234. *See, e.g.*, Janet A. Butler et al., *Modifiable Risk Factors for Non-Adherence to Immunosuppressants in Renal Transplant Recipients: A Cross-Sectional Study*, 19 NEPHROLOGY DIALYSIS TRANSPLANTATION 3144, 3144 (2004) (finding that "[l]ower belief in the need for medication and having a transplant from a live donor were the major factors associated with non-adherence [to immunosuppressants]. Depression was common, although not strongly associated with non-adherence."); Cohen et al., *supra* note 196, at 889 (reporting that, within a sample of seventy-nine dialysis patients, depression was not significantly associated with decisions to discontinue dialysis).

her illness, they often fail to reveal disordered perceptions and typically fail to take the motivational effects of disease-induced misperceptions into account. Because these standards assess only cognitive ability, they ignore depression's corrosive emotional impact on free agency altogether.

In sum, the law of medical decision making is inadequate to protect patients from the risks associated with illness-induced choices against medical interests. Current legal standards ensure that the patient is competent to make a medical decision, but they do not ensure that the patient's choice is authentic and voluntary. Current standards thus should be reformed to provide protection against coercion equivalent to that offered by other areas of law.

The law of wills offers an excellent model for needed reforms. First, the law of wills is responsive to goals extraordinarily similar to those underlying the law of medical decision making: Both areas of law are centrally concerned with effectuating autonomous individual choices on matters of considerable importance to the individual actor. Both areas of law treat unilateral decisions instead of bilateral agreements. Reflecting the unilateral character of the decisions at stake, in both areas of law there is consensus that the public interests in the actor's decision are outweighed by the individual interests of the decision maker.

Second, the law of wills has developed volitional doctrines that are readily adaptable to the medical decision-making context. The insane-delusion doctrine is aimed at uncovering distorted perceptions and beliefs that coerce a testator's bequests.[235] This doctrine, modified for the medical decision-making context, would seem to be an ideal vehicle for protecting patients suffering from disordered insight; after all, distorted perceptions and beliefs are key features of insight deficiencies. The undue-influence doctrine is aimed more generally at uncovering bequests to individuals who exert coercive pressure and thus overpower the testator's own preferences in favor of more obvious beneficiaries like close family members.[236] This doctrine, again modified for the medical decision-making context, would seem to be an excellent vehicle for protecting patients suffering from the corrosive emotional influence exerted by depression and hopelessness; these emotional conditions poison the minds

235. *See supra* notes 54-57 and accompanying text.

236. *See supra* notes 52-53, 58 and accompanying text.

of their victims against natural interests in life and health just as a scheming confidante poisons her victim's mind against relatives who are the natural objects of her bounty.

Finally, because neither the undue-influence nor insane-delusion doctrines are available when a testator makes a decision that comports with typical testamentary preferences,[237] adapted doctrines would naturally screen out only those medical decisions that pose serious risks to the patient's life or health. Use of these adapted doctrines thus should cure the parsimonious model's failure to protect nonautonomous actors from disease-induced choices that conflict with the patient's authentic values and medical interests without any efficiency loss.

The *Candura* decision described in Part I offers an excellent vehicle for demonstrating how this new approach would work. In its evaluation of the evidence, the *Candura* appellate court was exclusively concerned with determining whether the patient understood the risks and benefits inherent in the treatment choice; once the evidence showed that Mrs. Candura knew that her refusal to consent to surgery on her gangrenous leg would likely lead to her death, the court was satisfied that she was competent to make that decision.[238]

The new approach would require both the initial decision maker, in this case the investigating psychiatrist, and the appellate court to go beyond an assessment of Mrs. Candura's legal competence; these actors would additionally assess the possibility that Mrs. Candura's decision was coerced by disordered insight or major depression. The *Candura* opinion does not reveal any formal assessment of either depression or disordered insight.[239] It is thus difficult to determine, at this distance, just what the evidence would have shown.

However, we do know that diabetics like Mrs. Candura are at relatively high risk of depressive illness. Surveys show that about one-quarter of patients with type 2 diabetes are depressed, a rate higher than that reported in some surveys of the terminally ill.[240] As

237. *See In re* Kamesar, 259 N.W.2d 733, 739 (Wis. 1977).

238. *See* Lane v. Candura, 376 N.E.2d 1232, 1234-35 (Mass. App. Ct. 1978); *see also supra* notes 16-22 and accompanying text.

239. *Candura*, 376 N.E.2d at 1234-36 (detailing Candura's treatment with no indication of a depression or disordered insight screening).

240. *See* Kuszmar et al., *supra* note 223; *supra* notes 188-90 and accompanying text.

it does in other treatment contexts, depression also appears to have a major impact on diabetics' treatment choices and behaviors. Depressed diabetics are less compliant with dietary and medication directions than are other patients; as a result, they are at higher risk of uncontrolled glucose levels.[241] One meta-analysis of twenty-four studies examining the relationship between depression and glycemic control in diabetics thus found that depression was a highly significant correlate of hyperglycemia, which can accelerate the development of vascular complications.[242] Vascular complications cause gangrene, the condition for which Mrs. Candura was admitted to the hospital.[243] And depression that is "comorbid with vascular disorders ... is [often] accompanied by lesions in the basal ganglia and prefrontal areas of the brain."[244] Perhaps as a result of these lesions, "depression in patients with vascular disease is often characterized by motor retardation, lack of insight, and impairment of executive functions."[245]

It is thus plausible—perhaps probable—that Mrs. Candura was afflicted with major depression, disordered insight, or both. Under the wills-based approach to patient decision making that I have outlined, the psychiatrists who examined Mrs. Candura would have formally assessed the extent to which Mrs. Candura was depressed and tested her for disordered insight. If this assessment revealed either major depression or a serious insight disorder, Mrs. Candura would *not* be allowed to make a decision that would result in her death. Instead, the law would protect her from the coercive influence of her illness.

Just as it is impossible to assess coercive influences that may have afflicted Mrs. Candura in retrospect, it is also impossible to assess the possibility of coercion in the other reported decisions described in Part I. However, there appears to be a high probability

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241. *See* Kuszmar et al., *supra* note 223.

242. Lustman et al., *supra* note 205, at 939. Severe depressive symptoms significantly correlate with mortality risk among diabetics; depression's impact on diabetics also appears to be greater than it is on other individuals. *See* Xuanping Zhang et al., *Depressive Symptoms and Mortality Among Persons With and Without Diabetes*, 161 AM. J. EPIDEMIOLOGY 652, 654 (2005). Medication noncompliance may be an explanatory factor.

243. *Candura*, 376 N.E.2d at 1234.

244. Barry D. Lebowitz et al., *Diagnosis and Treatment of Depression in Late Life: Consensus Statement Update*, 278 JAMA 1186, 1187 (1997).

245. *Id.*

of coercion in each of these cases. Quackenbush, the court tells us, was suffering from an "organic brain syndrome,"[246] Bergstedt was "despair[ing],"[247] and Bouvia, the petitioner hospital maintained, was very depressed.[248] There is also a strong likelihood that the lucid suicide victim described in Part I[249] was depressed or insight-deficient: survey data show that more than 90 percent of suicide victims have a psychiatric illness identified in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*), most frequently depression, substance abuse, or both; bipolar disorder and schizophrenia are also both significantly linked with suicidality.[250] Moreover, experts have concluded that "the overwhelming majority of people who desire to kill themselves at one time will feel very different after improvement in their depression or after receiving help with other problems."[251]

Under the wills-based approach that I have outlined, formal assessment of disordered insight and depression would be required for each of these patients. If a coercive condition were found, the law would protect the patient from that influence by ordering medically indicated treatment.

The wills-based approach would not require assessment of coercive influences in all cases, of course. No assessment would be required if the patient made a decision in favor of a medically recommended treatment, if the patient decided against an extremely risky medical treatment, or if the patient chose to forgo a treatment offering minimal or uncertain benefits. Nor would coercion assessment be appropriate in cases where natural variation in risk aversion and personal values would likely produce frequent disagreement among autonomous decision makers. Thus the patient who decided to forgo painful and tiring treatment for pancreatic

246. *In re* Quackenbush, 383 A.2d 785, 788 (N.J. Super. Ct. 1978); *see supra* notes 26-30 and accompanying text.

247. McKay v. Bergstedt, 801 P.2d 617, 620 (Nev. 1990); *see supra* notes 31-34 and accompanying text.

248. *See* GARRISON & SCHNEIDER, *supra* note 9, at 261; *see supra* notes 35-37 and accompanying text.

249. *See* Hassan et al., *supra* note 38, at 107.

250. *See* Robert M.A. Hirschfeld & James M. Russell, *Assessment and Treatment of Suicidal Patients*, 337 NEW ENG. J. MED. 910, 911 (1997); J. John Mann et al., *Suicide Prevention Strategies: A Systematic Review*, 294 JAMA 2064, 2065 (2005).

251. Hirschfeld & Russell, *supra* note 250, at 914.

cancer, an almost invariably fatal disease,[252] should not be assessed; nor should the patient who decided against a risky bone marrow transplant, or the patient who concluded that she would rather reduce her high cholesterol level through dietary change instead of a recommended medication.

On the other hand, if the proposed treatment offers a good chance of curing or significantly improving a serious and debilitating medical condition, then assessment of coercive influence is warranted. The patient who refused anti-psychotic drug treatment for schizophrenia should certainly be assessed, as should the patient who opted against treatment for glaucoma and the patient who refused surgery that offered a high probability of restoring or preserving mobility.[253]

If assessment shows the existence of coercion induced by depression or disordered insight, a guardian would be appointed to make treatment decisions on the patient's behalf. Just as in the case of an incompetent patient, the guardian would continue in this role until examination revealed that the coercive influence has been removed. The guardian would be charged with making decisions in the best interests of the patient and would have decision-making authority with respect to all aspects of the patient's medical care. Although constitutional doctrine and state law disallow commitment of a mental patient to a psychiatric treatment facility without a showing of danger to the patient or others,[254] the guardian should be empowered to consent to all other forms of treatment, including so-

252. *See* Jill P. Smith et al., *Drug Retention and Distribution After Intratumoral Chemotherapy with Fluorouracil/Epinephrine Injectable Gel in Human Pancreatic Cancer Xenografts*, 44 CANCER CHEMOTHERAPY PHARMACOLOGY 267, 267 (1999).

253. Decisions respecting participation in research trials present more difficult issues that are beyond the scope of this Article. Research-trial participation sometimes offers the possibility of direct therapeutic benefit, and sometimes it does not. The risks of participation may be minimal, large, or unknown. Certainly, when research risks are minimal, the assessment of coercive influences is unnecessary; certainly, when the risks are large and potential benefit unclear, assessment of coercive influence is necessary. Many research trials will not fall into one of these two clear-cut categories, however.

254. *See* Addington v. Texas, 441 U.S. 418, 433 (1979) (requiring clear and convincing evidence of danger to self or others); O'Connor v. Donaldson, 422 U.S. 563, 575-76 (1975) (holding that the state could not constitutionally confine a nondangerous individual). State commitment requirements and procedures now conform to the *O'Connor-Addington* requirements. *See* Foucha v. Louisiana, 504 U.S. 71, 94 (1992) (Kennedy, J., dissenting).

called "outpatient commitment," involving mandated medication checks but no loss of liberty.[255]

### *B. Matters of Measurement*

Ideally, we would have a simple, widely accepted, and standardized assessment procedure that, with a very high degree of accuracy, would classify patient decisions as coerced, due to major depression or insight impairment, or voluntary. We do not, at this point, have such an instrument.

Although law reform of the sort I have described will undoubtedly spur the development of assessment procedures aimed specifically at the coercive effects of depression and insight impairment, today's diagnosticians will need to rely on assessment protocols aimed more generally at determining levels of insight impairment and depression. These protocols typically produce incremental scores instead of either/or conclusions. They also vary enormously in length and complexity. For example, depression can be measured with a one-question or thirty-question inventory.[256] Insight scales range from the seventy-four-item SUMD to the one-item Present State Exam (PSE).[257]

Adding complexity, the various scales do not all measure the same variables. Thus the SUMD fails to assess the patient's perceived need for treatment, while some other insight-measurement scales fail to assess awareness of treatment benefits, awareness of signs and symptoms of the relevant disorder, or attribution

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255. *See* Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1291 (2000) (describing and advocating outpatient commitment schemes). Some state laws require a showing that the patient poses a danger to self or others as a precondition to outpatient as well as inpatient commitment. *See id.* at 1290-91, 1297. These statutes should be liberally interpreted to include danger to self as a result of medication noncompliance; because outpatient commitment involves no significant loss of liberty, a dangerousness requirement would not appear to be constitutionally mandated. *Id.* at 1299.

256. *See* Jagannadha R. Avasarala et al., *Comparative Assessment of Yale Single Question and Beck Depression Inventory Scale in Screening for Depression in Multiple Sclerosis*, 9 MULTIPLE SCLEROSIS 307, 308 (2003) (comparing single and twenty-one-item scales); A. John Rush et al., *Comparison of Self-Report and Clinician Ratings on Two Inventories of Depressive Symptomatology*, 57 PSYCHIATRIC SERVICES 829, 829 (2006) (comparing thirty-item Inventory of Depressive Symptomology and sixteen-item Quick Inventory of Depressive Symptomology).

257. *See* Amador & Kronengold, *supra* note 107, at 10 tbl.1.1 (comparing insight-assessment tools by number of items).

of signs and symptoms to having a particular disorder.[258] Depression scales, too, vary in their focus. For example, the widely used Hamilton Depression Scale deviates from official DSM-IV criteria for assessing symptoms associated with depression.[259] Again adding complexity, some of the diagnostic symptoms associated with depression—for example, loss of appetite and fatigue—are also associated with physical illness.[260] It may not always be obvious whether the patient's symptom is due to his disease, depression, or both.[261]

Despite these various difficulties, many rating scales produce highly consistent results when used by experienced clinicians.[262] There is also a depression-assessment procedure (DISH), specifically "designed to minimize respondent burden without sacrificing the thoroughness or accuracy of the interview," that that has been developed for medically ill patients.[263] In a comparative survey, interviewers utilizing this procedure produced results that corresponded closely with longer and more detailed assessment protocols.[264] And researchers are working on disease-specific depression-assessment tools to improve categorization of ambiguous symptoms.[265] In a close or difficult case, clinicians searching for coercive insight impairment or depression might need to use more than one assessment protocol to ensure accurate results.

Of course, the length and complexity of assessment procedures must take account of the patient's underlying condition; in emer-

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258. *See id.* at 13 tbl.1.2 (showing dimensions of insight assessed in various assessment tools).

259. *See* R. Michael Bagby et al., *The Hamilton Depression Rating Scale: Has the Gold Standard Become a Lead Weight?*, 161 AM. J. PSYCHIATRY 2163, 2170 (2004) (concluding that "[s]everal symptoms contained within the Hamilton depression scale are not official DSM diagnostic criteria, although they are recognized as features associated with depression (e.g., psychic anxiety).... More critically, important features of DSM-IV depression are often buried within more complex items and sometimes are not captured at all.").

260. *See* Williams et al., *supra* note 187, at 1161 tbl.1 (citing DSM-IV).

261. *See id.* at 1160.

262. *See supra* notes 146-47 and accompanying text.

263. Kenneth E. Freedland et al., *The Depression Interview and Structured Hamilton (DISH): Rationale, Development, Characteristics, and Clinical Validity*, 64 PSYCHOSOMATIC MED. 897, 897 (2002).

264. *See id.* at 902.

265. *See, e.g.*, Avasarala et al., *supra* note 256, at 307; Anette Schrag et al., *Depression Rating Scales in Parkinson's Disease: Critique and Recommendations*, 22 MOVEMENT DISORDERS 1077, 1077 (2007).

gency situations, a thorough assessment will often be impossible.[266] Consider, once again, the case of the suicide victim who rejects treatment in the emergency room.[267] If full evaluation is medically inappropriate, the physician should rely on minimal screening tools: there is a two-question depression screen that, even in an emergency-room setting, produces results fairly consistent with those produced by more detailed assessment tools;[268] there is also a two-question insight-assessment tool for emergency use.[269] If evaluation produces equivocal results, the strong correlation between a suicide attempt and serious psychiatric illness justifies a presumption of coercive influence.[270] Thus only clear evidence that the patient's suicide attempt was genuinely voluntary should justify acceding to a suicidal patient's nontreatment request.

In sum, although a standardized, consensus procedure for assessing the coercive influence of depression and disordered insight is not yet available, existing assessment tools are adequate to determine whether a patient's choice is determined by her own goals and values or by her illness. Multiple forms of assessment may sometimes be necessary. Emergency situations may require reliance, at least initially, on partial assessment or presumption. If screening for coercion becomes commonplace, however, it is likely that standardized, streamlined assessment protocols will become available.

## CONCLUSION

The current law of medical decision making fails to protect vulnerable patients whose free agency has been lost to the empire of illness. A large and growing body of evidence shows that disordered insight and major depression, two common medical condi-

266. *See* Freedland et al., *supra* note 263, at 901 (indicating that the minimized DISH depression-assessment procedure required, for patients ultimately diagnosed as having major depression, more than an hour to conduct).

267. *See* Hassan et al., *supra* note 38, at 107.

268. *See* F.M. Hustey, *The Use of a Brief Depression Screen in Older Emergency Department Patients*, 12 ACAD. EMERGENCY MED. 905, 906-07 (2005); E.G. Scott et al., *Screening for Adolescent Depression in a Pediatric Emergency Department*, 13 ACAD. EMERGENCY MED. 537, 540-41 (2006).

269. *See* Amador & Kronengold, *supra* note 107, at 10 tbl.1.1.

270. *See supra* notes 221-22.

tions, often have a large and negative effect on treatment choice and compliance. When patients are afflicted with disordered insight or major depression, a decision against treatment thus is likely to represent the illness talking instead of the patient.

The undue-influence and insane-delusion doctrines developed within the law of wills to detect and disarm coercive influences are readily adaptable to the medical decision-making context. There is a wealth of assessment protocols that offer reliable methods of detecting the influence of depression and insight deficits. The same clinicians who today assess competence alone thus could easily assess coercive influences as well.

Vulnerable patients need, and deserve, protection from the coercive effects of distorted perception and motivation just as much as vulnerable testators need and deserve protection against scheming gold-diggers. It is time to reform the law of medical decision making to ensure that it provides such protection. Patient health—and life itself—hang in the balance.