Robert Weinstock,[1] *M.D.; Russell Copelan,*[2] *M.D.; and Abbas Bagheri,*[3] *M.D.*

Physicians' Confusion Demonstrated by Competency Requests

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ABSTRACT: A study was performed at a Veteran's Administration (VA) Hospital of the requests for competency evaluations made by medical and surgical services to a psychiatric consultant service. Since less than half the requests were found to be appropriate and specific, this study emphasizes the need for forensic psychiatrists to educate our nonpsychiatric colleagues about the problems engendered by confusion regarding competency. To do so, psychiatrists as well as other physicians and mental health professionals must be trained in discriminating between different types of competencies and the criteria appropriate for each. Because of continuing legal developments, it is becoming increasingly essential to be precise not only about the specific purpose for a competency request but also about the criteria necessary for evaluating different types of competencies. Forensic psychiatrists could play an important role in the education process to clarify the confusion. This study highlights the need for clarity and education concerning competency issues.

KEYWORDS: psychiatry, competency, medical personnel

Competency assessments are frequently made by psychiatrists at the requests of nonpsychiatric physicians. Although competency is a legal issue, emergency situations, the reluctance of hospitals to take the time to go to court, or delays in court proceedings often necessitate that a psychiatrist make an assessment which, in reality, frequently serves as the only determination of competency. However, most psychiatrists have little training in the relevant legal issues involved in such evaluations; and, in addition, most requests are made by people with even less knowledge of possible ramifications.

Because of continuing court decisions, the determination of competency has developed into a complex legal matter. It is, therefore, currently more essential than ever to be specific about the particular purposes and criteria involved when a competency assessment is made [*1*]. It is crucial that forensic psychiatrists become involved at least in the education process, if not in the role of consultant, when difficult situations arise. Complexities and confusion are common. However, the situation is not truly different from other types of competency evaluations, such as testamentary capacity or even competency to stand trial, when forensic psychiatrists routinely do become involved.

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[1]Associate clinical professor of psychiatry, University of California, Irvine, CA and affiliated with Department of Psychiatry, Long Beach VA Hospital, Long Beach, CA.

[2]Formerly, resident in psychiatry, University of California, Irvine, CA; presently, private practice, Colorado Springs, CO.

[3]Associate clinical professor of psychiatry, University of California, Irvine, CA and affiliated with Department of Psychiatry, Long Beach VA Hospital, Long Beach, CA.

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There have been few guidelines and courts have often ruled inconsistently, but court decisions and legislation have gradually led to the development of specific criteria for some types of competencies. For example, in the areas of competency to stand trial [2], or competency to make a will [3], criteria have been established that are quite specific. In others, such as competency to give informed consent [4], the criteria have been much less well-defined.

In the past, psychiatric patients would be considered incompetent for all purposes just because they were hospitalized psychiatric patients. Even voluntary psychiatric patients were considered automatically incompetent for all purposes such as voting, making a contract, marrying, or driving an automobile [5]. Such assumptions obviously are contrary to the usually presently acknowledged fact that patients who are incompetent for one purpose could be competent for another. Recognition of this fact is becoming increasingly evident in recent legislation and court decisions, which emphasize the need to be precise about the specific purpose in question. One series of court decisions [6] has gone so far in this direction that it states that just because a nondangerous patient meets the criteria for involuntary hospitalization, it does not mean that he can be given psychotropic medication and treatment. The decision requires that at the same time he is committed for involuntary hospitalization, he is adjudicated incompetent to give informed consent to or to refuse that treatment and that a substituted judgment treatment plan approved by the courts must be developed.

Though some courts still occasionally judge patients globally incompetent in all situations, the majority judge a patient incompetent only for a specific purpose, since it is possible to be competent for one purpose, yet incompetent for another. A demonstration of the widespread confusion is reflected in an article by Abernathy [7] in the *American Journal of Psychiatry*. She proposed a return to the standard of considering a patient incompetent to consent to medical treatment only if he is also generally incompetent and unable to make ordinary decisions on matters unrelated to the crisis on hand.

In our opinion, such a proposal would be counterproductive, unusual, regressive, and more confusing. If adopted, it would lead to a standard that does not always reflect clinical realities. Watson [8] has commented in regard to Abernathy's case of a patient who refused a leg amputation and was declared incompetent, that a more skillful examination would probably have led to an assessment of delusional thinking about health and well-being. In the case described by Abernathy, the physicians and court exhibited a lack of clarity about the specific issues that needed assessment. They apparently equated competency with an agreement to go along with "good medical advice" and resulting consent to have the leg amputated. Incompetency was equated with refusal. The patient was described as otherwise lucid. They gave no justification for their assessment of incompetency.

Abernathy's reaction to the confusion presented in the above case was not only to accept the confusion of the physicians and judge as a valid application of current standards, but also to suggest that a solution to the problem would be a return to a standard that would judge a person incompetent for this specific purpose only if he is also incompetent for all purposes or for totally unrelated purposes. In our opinion, her suggestion is reflective of the widespread confusion in this field. The psychiatrists and courts in Abernathy's paper apparently believed that refusal to go along with "good medical advice" automatically indicates incompetency. Such a conclusion and the absence of discussion of existing alternatives in her paper manifest an absence of understanding of relevant standards for judging competency both by her and by the physicians and judge in her paper. She ignores possible specific tests for competency to give informed consent. Her paper's publication in such a widely read journal as the *American Journal of Psychiatry* will probably exacerbate confusion in the field and is itself reflective of such confusion. Contrary to her belief that the solution is a return to a general incompetency standard as the only standard of competency, there are other existing alternatives [5, 9, 10].

As Watson [8] has written, Abernathy's drastic proposal would greatly modify the law regarding competence, and it would prevent social interventions and help for people unless they were found incapable of doing anything for themselves. The manifest confusion in

Abernathy's paper highlights the need for involvement by forensic psychiatrists. In our opinion, it is much more meaningful to consider a person incompetent in reference to a specific issue rather than to require general incompetency. This approach is the more usual one and more in agreement with recent legal trends. Utah [*11*] even requires a separate assessment of competency for committed patients as part of the commitment process since the criteria for commitment do not otherwise include incompetency to consent to treatment. When medical patients are evaluated for competency, the precise issues, such as competency to give informed consent or to handle funds, should be specified. Just because a patient is sufficiently mentally ill to be unable to provide for food, clothing, or shelter does not necessarily mean that he cannot make a rational decision about whether to amputate his leg, or for another example, whether to consent to castration to treat a malignancy. He may be unable to perform complex tasks but he still may be able to understand the risks and benefits of having a leg amputated or being castrated.

There are, of course, times when a patient may be so impaired that he would be judged incompetent for all purposes, or there may be a slightly limited guardianship (a conservatorship in California). Other states have similar categories. However, it is important that an individual not be considered automatically incompetent for a particular purpose just because he has been found incompetent for another. A patient may be incompetent to give informed consent to abdominal surgery if he believes he has two stomachs as part of a delusion. However, he may still be competent to handle his finances if his delusions do not otherwise interfere with his handling of money. Misunderstandings of these distinctions could lead to injustices to patients and legal problems for the physicians involved.

Because the determination of competency is a complex and controversial issue and because psychiatrists are frequently asked to make competency assessments, in the present study we evaluated the appropriateness of psychiatric consultation requests for competency evaluations that we received from our nonpsychiatric medical colleagues. Misunderstandings and confusions in such requests could lead to inappropriate competency assessments, especially if nonforensic psychiatrists were doing the evaluation, as is usually the case, and if they themselves were also not clear about the facets and distinctions involved. In such a situation, they might make their assessments solely on the basis of the psychiatric diagnosis or other considerations without considering the ramifications of the specific issues involved. In emergency situations, evaluations cannot be reviewed by a court, making it especially apparent that clarity in competency requests is essential. If there are confusions in requests as well as confusions by the psychiatrist performing the evaluation, there could, at times, very well develop inappropriate competency assessments and consequent legal problems.

Method

The data obtained were from the consultation requests made from the nonpsychiatric wards at a Veterans Administration (VA) Hospital to the psychiatric consultation service. The authors performed all consultations that were made during a six-month period from October 1981 to March 1982, in which a request was made for a competency evaluation. A total of 66 consults were thus obtained. The study was done prospectively and the consultations were performed by the authors. Although there was no formal reliability check employed, unclear consults were discussed among the authors, one of whom is a board certified forensic psychiatrist.

The requests were rated in three categories as to whether (a) they were appropriate to that patient's situation, (b) inappropriate to what was relevant, or (c) merely a general request for competency without specifying the precise purpose for the competency request or the specific competency to be evaluated. Separate ratings were made when placement or conservatorships were at issue. The separation of placement was made because of the large number of especially inappropriate consults for placement as a result of the stringent criteria used for mental health conservatorships in Los Angeles County as well as the absence of long-term mental health com-

mitments in California. The separations were made to avoid an unfair bias in the results because of an exaggeration of inappropriate requests. The other issues during our study period primarily involved competency to handle finances or competency to give informed consent or both. During the course of each consultation, an attempt was made to educate the house staff and social workers regarding different types of competency.

Case Examples

Patient A

An example of a patient where competency was requested when it was not appropriate was a 41-year-old blind man who was not cooperating with his rehabilitation program. The physician, in anger, requested a psychiatric consultation for the purpose of declaring the patient incompetent. Discussion with the physician did not clarify what type of incompetency was being requested or how such a determination would help persuade an unmotivated patient to cooperate with his program. Instead, the consultation appeared to be a way of punishing the patient and calling his behavior "crazy." Mediation and clarification of some misunderstandings between patient and staff proved more useful and led to improved cooperation by the patient. He was not found to have any mental illness other than an adjustment disorder secondary to his disability. He was competent and the issue about his competency was not really relevant or appropriate.

Patient B

Another patient where competency assessment was requested inappropriately was an 84-year-old man who was confused and agitated on the medical ward. Discussion with his physician revealed that there was no real competency issue in question but really a matter of how to manage this patient's agitation. Mild doses of a neuroleptic were recommended, alleviating the problem. The patient was cooperative and his competency was not in question.

Patient C

An example of a general competency request which was not specific occurred with a 57-year-old man with Huntington's chorea. Discussion with the physician showed that the real issue was whether the patient could manage his VA finances. In spite of pronounced physical movements and some memory difficulties, which might make him incompetent for some purposes, the patient was able to do calculations involving money, knew how much money he received, and what the costs of most items were. He was considered by us to be competent to handle his VA finances. The original consultation request for a competency assessment was not specific about what type was needed.

Patient D

Another example of a general competency request was one by a medical service for a 31-year-old man with a history of meningioma with a craniotomy 10 years previously, right eye blindness, and a seizure disorder. He was being treated with phenobarbital and Dilantin® with therapeutic blood levels. He had a history of belligerent behavior. As a result of the consultation, there were indications that the real reason behind the request was that the patient was a behavior problem. A probate conservatorship was being considered because it was felt that he exhibited too poor judgment to care for himself. He was well-oriented with no memory problems, but was frustrated with his physical disabilities and uncooperative. An opportunity to ventilate his frustrations proved helpful. The competency request appeared to evolve from staff frustration with their inability to control the patient sufficiently. Although he was a man-

agement problem, in our opinion, he did not meet the criteria for a probate conservatorship. The original consult request was general and had not specified the type of competency assessment needed.

Discussion

The results of this study as described in Table 1 indicate a large degree of misunderstanding underlying requests for competency evaluations by our medical colleagues who ask for psychiatric consultations. Less than half the requests were appropriate and specific. A good percentage were either general or totally inappropriate. Although this study is of a particular VA Hospital which is a major university teaching hospital, it is likely that, if anything, our study underestimates the degree of misunderstanding since an attempt was made during each of our consults to educate the house staff about competency requests. Therefore, the number of otherwise inappropriate consults was probably decreased through the education process. In addition, some inappropriate competency requests were cleared up by an informal telephone consult, again decreasing the number of inappropriate consults in our sample.

Our subjective impression was that the general, or nonspecific, competency requests usually appeared to reflect either a lack of knowledge of the specific types of competency that exist or a misconception that a determination of global competency for all purposes was indicated or necessary. In many cases it would require an evaluation of a patient's competency in many different situations to declare a patient incompetent for all purposes. Unless a patient had a severe organic brain syndrome, such an evaluation would usually be impossible. Even many patients with a relatively mild dementia can be competent for some purposes.

Sometimes, inappropriate consults involved a hope that a judgment of incompetency would allow the doctors or social workers to proceed as they wished with a patient in all present or future situations even though there was only a specific situation at issue at the time, or the patient was merely uncooperative. Sometimes, discussion with the referring physician revealed that the physician wanted the patient transferred to the inpatient psychiatry service and that he did not have a real competency question in mind. The inappropriate requests involved an evaluation for a type of competency not relevant or necessary for the patient's current condition. These were described in Table 2.

Inappropriate consults for placement usually resulted from an unawareness that in Los Angeles County, patients with organic brain syndromes ordinarily cannot be put on mental health conservatorships, but should be placed on probate conservatorships. Alternatively, inappropriate consults sometimes resulted from a mistaken belief that a determination of incompetency for all purposes was needed to place a patient in a nursing home.

This study underscores an obligation to educate our medical and surgical colleagues regarding specific types of competency to insure that patients declared incompetent are so judged for the right reasons and for the right purposes. Although this study did not look at confusion by evaluating psychiatrists, their confusion could also be clarified by a forensic psychiatrist. Presently, some court decisions even ask psychiatrists and courts to make additional competency evaluations for informed consent for psychiatric medicines [*6*]. The problem could be resolved by the legislature, as in Utah, or perhaps by allowing the psychiatrist himself to make the competency assessment with the potential for a review process as in New Jersey [*12*]. Some jurisdic-

TABLE 1—*Appropriateness of consults.*

	Placement	Other Issues	All Issues
Appropriate	2	23	25
Inappropriate	10	15	25
General	0	16	16

TABLE 2—*The types of inappropriate requests for competency (excluding outside placement issues).*

Types of Inappropriate Consults (Excluding Outside Placement)	Number
Request for total incompetency when not appropriate or necessary	8
Physical, not mental incapacity at issue	3
Physicians wish transfer of patient to psychiatry—not real competency question	2
Request to place uncooperative patient on an involuntary psychiatric hold when not a psychiatric problem	2

tions ignore the problem and are ready to adjudicate patients incompetent to give informed consent if they are gravely disabled (that is, unable to provide for food, clothing, and shelter secondary to mental illness) [*13*]. Although the two criteria could overlap, they do not always do so.

On consult services, competency requests are quite frequent. Few of these evaluations are ever reviewed by a court, especially in emergency situations or when financial matters are at issue, such as competency to handle VA funds, and no one appeals the decision. Because at times, even judges and attorneys can become confused about the criteria, it becomes evident that we must be aware of the relevant criteria so that we can educate our nonpsychiatric colleagues as well as our psychiatric colleagues without forensic psychiatric training to use them discriminately. In addition, since the patient was probably evaluated for only one purpose, that assessment should not be used automatically for another purpose. Although a diagnosis of an organic brain syndrome may often imply in severe cases that a patient is incompetent for everything, in milder cases, of course, that patient actually may be incompetent for one particular purpose but not for another.

Another danger of a hasty general judgment of incompetency is that it could too readily be taken to mean that a patient is forever incompetent for all purposes, particularly if the patient is never reevaluated. Even many patients with organic brain syndromes can improve with time, and there is a danger that such a patient may not be reviewed if there is a misunderstanding that leads to a conclusion that a patient who has been judged totally incompetent will remain so forever thereafter. Such global judgments of incompetence are rarely necessary or even possible.

Once a patient is declared incompetent for a specific purpose, the legal process, of course, will vary in differing states. In reality, in emergency situations the psychiatrist will often be in the position of making the final decision for all practical purposes. This responsibility includes an obligation to clarify the issues involved in his evaluation.

This study highlights the fact that confusion about competence is prevalent among our nonpsychiatric colleagues. Although the study did not look directly at possible confusions among some evaluating psychiatrists, it nevertheless emphasizes the need for psychiatrists to be clear themselves regarding the purpose for which a particular competency request is made. It further accentuates the urgency for clarity concerning the various criteria appropriate for different types of competencies. It is likewise essential to stress that patients may be incompetent for one purpose and competent for another.

It is especially important that forensic psychiatrists become involved in the education process. This study shows that the majority of nonpsychiatric medical and surgical physicians at this VA Hospital were confused about the competency issues involved. Since we were actively involved in the educational process about competency issues, we probably diminished the confusion which otherwise would have existed. It is therefore likely that confusion about competency issues is present to an equal or greater extent at many other hospitals. If the psychiatrist who is performing the evaluation has no forensic psychiatric training, as is usually the case, it is very possible that he will also be confused. It is therefore important that even though forensic psychiatrists might not do the evaluations themselves, they at least become involved in this of-

ten neglected area. Perhaps the most practical role would be for forensic psychiatrists to become more involved in the consultation process when difficult situations arise. Although it has not been traditional to do so, in our opinion, forensic psychiatrists should concern themselves with the education of our fellow psychiatrists, mental health workers, and medical and surgical colleagues in the area of competency issues.

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Address requests for reprints or additional information to
Robert Weinstock, M.D.
333 First St. #E112
Seal Beach, CA 90740