DECIDING FOR THOSE INCAPABLE OF MAKING TREATMENT DECISIONS

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I. Introduction

This article examines methods of treatment decisionmaking\(^2\) for individuals not capable of making treatment decisions, with an application to seriously mentally ill individuals. Advance directives, substituted judgments, and the best interest principle are each discussed in turn,\(^3\) and then the Article deploys the methods discussed to those mentally ill.

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1 I thank Fuller Torrey, Elyn Saks, Donna Meck, Eric Freedman, and especially Charles Fisher, and Gary Lawson for helpful comments.

2 Although grammarians prefer "decision making," I deploy "decisionmaking," in part because it indicates the unity of the act.

In the course of the examination, a number of restrictive principles emerge. No one is entitled to a treatment decision he couldn't have authorized if capable. He may not receive active euthanasia.\textsuperscript{4} He may not receive any and all treatments, especially when they impose excessive costs or burdens on others.\textsuperscript{5} He may not receive a treatment not within accepted medical practices\textsuperscript{6} nor one outside the treating physician's professional conscience.\textsuperscript{7} In particular, he may not receive, under ordinary circumstances, no treatment.\textsuperscript{8} He has no right to unorthodox treatments.\textsuperscript{9} If a new, better treatment has been developed since he executed his advance directive or became incapable of making treatment decisions, any decision not giving full weight to the new treatment is improper. He may not receive a treatment he cannot afford. He cannot receive a treatment that would risk death or serious injury.\textsuperscript{10}

I. Advance Directives

When an individual is incapable of making treatment decisions, the attending physician or treatment team is legally required to follow a valid advance directive the patient has executed, although they frequently illegally and offensively ignore them, thereby disrespecting the declarant. Following an advance directive arguably

\textsuperscript{4} Allen E. Buchanon & Dan W. Brock, supra note 3, at 92.
\textsuperscript{5} Allen E. Buchanon & Dan W. Brock, supra note 3, at 92(burdening others with significant health risks).
\textsuperscript{6} E. Fuller Torrey, Head, Stanley Medical Research Organization, in conversation.
\textsuperscript{7} Linda Hinton, Iowa Dept. Human Services, Head, Mental Health/Developmental Disabilities Division, at the time of that conversation.
\textsuperscript{8} E. Fuller Torrey, in conversation.
\textsuperscript{9} E. Fuller Torrey, in conversation.
\textsuperscript{10} Buchanan & Brock, supra note 3, at .
respects self-determination and patient autonomy.\textsuperscript{11} Patient well-being is advanced because everyone is the best judge of his own self-interest.\textsuperscript{12} It can preserve medical well-being by avoiding expensive and futile medical interventions.\textsuperscript{13} It promotes altruism by avoiding medical treatments that would impose financial or emotional costs on others.\textsuperscript{14} Each of these grounds is problematic when closely scrutinized. Following an advance directive need not respect current self-direction and autonomy.\textsuperscript{15} The declaration reflects the autonomous desires of the patient at the time the advance directive was executed, not the self at the time of treatment decision. These could easily differ, especially if the patient is mentally ill. When mentally ill close to or at the point of incapacity, the patient may become paranoid, be fearful of the treatment team, and reject even a treatment he had previously requested in an advance directive. Respecting the authority of an advance directive may not respect current autonomy. Following an advance directive may not promote patient well-being. Not everyone knows their own best interests.\textsuperscript{16} Even when they do, they might make a mistake in the advance directive. A patient is less likely to know his best interest about a distant future possible treatment under radically varying circumstances. A medical treatment rejected in an advance directive may be therapeutic and worth its cost.\textsuperscript{17} An advance directive may selfishly

\textsuperscript{11} Buchanan & Brock, supra note 3, at .
\textsuperscript{12} Well stated in modern economics.
\textsuperscript{13} Buchanan & Brock, supra note 3, at .
\textsuperscript{14} Buchanan & Brock, supra note 3, at .
\textsuperscript{15} Well stated in modern philosophy.
\textsuperscript{16} Buchanan & Brock, supra note 3, at.
\textsuperscript{17} Buchanan & Brock, supra note 3, at.
reject a medical intervention that would promote the emotional and financial well-being of others.\textsuperscript{18} Thus, the above grounds supporting advance directives are seriously blemished.

The limitations noted in the introduction to this Article apply to advance directives. An advance directive not in the declarant's best interest arguably should be overridden, particularly if it risks permanent injury or death.\textsuperscript{19} In particular, a request for no treatment should be invalidated when therapeutic treatments exist. However, a paternalistic exception risks abuse. The patient's relatives may have interests adverse to the patient, for example, to inherit from the patient. Either a durable power of attorney without conflicts of interest with the declarant or the attending physician should be authorized to make treatment decisions when relatives choose treatments substantially opposing the declarant's interest, or if there has been abuse or neglect.

Moreover, following an advance directive is problematic for many reasons. The patient may have been incapable when executing the advance directive. Even if capable, the patient may not have understood and contemplated the patient's current condition. People are not talented at understanding distant, future, contingent circumstances. The act of issuing the advance directive may not have been voluntary. The surrogate decisionmaker chosen in the advance directive may not be capable. Or he may not be adequately informed, or may be unwilling to act as

\textsuperscript{18} Buchanan & Brock, supra note 3, at .
\textsuperscript{19} Buchanan & Brock, supra note 3, at .
surrogate decisionmaker. Even if informed and willing, the surrogate may not decide in accordance with the instructions in the advance directive or the patient's autonomous desires or values, or the patient's best interest. The advance directive may be vague or ambiguous and therefore difficult or impossible to apply—it's almost impossible not to be. The advance directive may have been executed three, or ten years ago, and the patient's desires may have changed. Some would urge that declarants be required to keep their advance directives up to date.\textsuperscript{20} However, only 6\% of those with mental illness execute advance directives.\textsuperscript{21} Fewer might do so if the burden of revising them were required. The patient may have been wrong about what he or she wanted. On the other hand, we generally grant people the liberty to be wrong about their wants and desires because not doing so would be a great insult to their liberty and dignity.\textsuperscript{22} We commit people to contracts and wills when they mistake their desires. If the advance directive is not currently in the patient's best interest, it can plausibly be contended that it should be overridden, especially because an incapable person may well not be an autonomous person, and therefore not be deserving of the respect properly accorded to autonomous persons. Indeed, medical facts may have changed.\textsuperscript{23} There may be a newer, preferable treatment to the one the patient choose in his or her advance directive, which is more therapeutic for most patients and with fewer side effects, and which the patient would have

\textsuperscript{20} Donna Rae Meck, then patient advocate, requiring her to protect the medical interests of her clients, in conversation.
\textsuperscript{21} Swanson, et al. Get cite.
\textsuperscript{22} Eln Saks, Professor of Law Specializing in Mental Health Law, in conversation.
\textsuperscript{23} Psychiatrists in attendance at meeting regarding advance directives bill, several years ago, in conversation.
chosen if he or she had known of it. Or, a rational patient may have chosen it.\textsuperscript{24}

Moreover, due to new medical facts about the patient, the treatment the patient chose may now risk serious medical complications or even death.\textsuperscript{25} Had the patient known this, he would have chosen a different treatment. Even if he wouldn't have, a rational patient would have. The declarant has no right to treatments that he cannot afford, or to refuse treatment if it would impose grievous burdens on others.

II. Substituted Judgment

A. The Traditional Test

If there is no advance directive, or if the advance directive is not applicable to the current circumstance, it is generally thought the attending physician or treatment team should apply the substituted judgment test. That test is generally put as follows: provide the treatment the patient would have chosen if competent to make treatment decisions. It is well known that, as a practical matter, it is virtually impossible to determine what a patient's substituted judgment is.\textsuperscript{26} The substituted judgment test is claimed to express the patient's autonomous rights because the patient's competent choice is argued to be his real autonomous choice. Moreover, it is held to best satisfy his welfare because everyone knows their interests better than anyone else. Both these arguments are found wanting when carefully examined. As

\textsuperscript{24} Paul Applebaum, Md., formerly head/President, APA, in email.
\textsuperscript{25} See infra note
\textsuperscript{26} Barry R. Furrow, Thomas L. Greaney, et al., Health Law (2d. ed. 842, Sec. 16-18; 852, Sec. 16-24 2000) "Unfortunately, it is often difficult to know with any certainty what kind of treatment a patient would desire in any particular instance."}
with an advance directive, a competent self's substituted judgment may be mistaken, and not express the patient's real autonomous choice. As with an advance directive, a patient's substituted judgment that is not in his best interests arguably should be overridden. In fact, both law and morals override a judgment in these circumstances. Moreover, the best evidence of a patient's substituted judgment generally is the testimony of close relatives. But in many circumstances their interests and the patient's diverge, for example, if the patient does not receive life-saving treatment, dies, and the relatives inherit. This alone should raise eyebrows at substituted decisions not in the patient's best interest. For all these reasons, a substituted judgment may not maximize the patient's welfare.

Not only is there a practical difficulty in determining anyone's substituted judgment, at a deeper, theoretical level, the substituted judgment is frequently indeterminate. This is a new understanding in the current article, although its support is so transparent it should have been common knowledge. There is more than one way for an individual incapable of making treatment decisions to be capable, and when constituted capable differently the patient may well choose different treatments. Even if we could practically discover a patient's substituted judgment, the doctrine would still be seriously deficient. The substituted judgment doctrine is inadequate at its core. It doesn't get off the ground.

For example, consider the currently most sophisticated analysis of incapacity, the MacArthur study and analysis. Under that analysis, there are four factors relevant
to capacity: being able to consistently state a treatment choice, understanding what is told you about the pros and cons of the available alternative treatments, appreciating that you need to make a choice, appreciating how the alternative, available treatment options will affect you, and being capable—at least in some rudimentary manner—of weighing and balancing the alternative treatments, and choosing one as preferable. It follows that one can improve a patient's treatment capacity by improving his or her ability along any one, two, three, or all four of these factors. A sufficient improvement will render an incapable patient capable, although the analysis explicitly does not determine which improvements result in capacity. Yet some improvements are so vast that individuals acquiring them are undeniably capable. Nonetheless, there are multiple ways to make an incapable patient capable, and when made capable in different manners, a patient may well choose a different treatment than when made capable in a different way. The substituted judgment standard is indeterminate at a deep theoretical level.

Further, the test is generally misstated, even by its proponents. It is not what an individual would have chosen if capable; if capable, the patient might have taken a trip around the world, and spent the funds necessary for one or more of the

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27. In fact, being able to consistently state a treatment choice is not relevant to capacity—consider an individual with Lou Gehrig's disease who is capable of making competent treatment decisions, but cannot communicate them. Nonetheless, as a practical matter, unless you can communicate your treatment choice, the doctor cannot carry it out.

28. The MacArthur analysis mistakenly underestimates the resources available for capable decisionmaking. In addition to weighing and balancing the available treatments oneself, one can have someone else do it for you. Especially someone you know to be an expert, and who knows how you value possible treatment outcomes. Your doctor believes you should follow his advice because he is an expert, although he generally ignores that he doesn't know how you value various treatment outcomes as well as you do.
treatment options. Rather, under this understanding of the test, it should be understood as what the patient, if competent, would have chosen for himself in his current condition, including his incapacity.

B. A Test That Better Respects a Patient’s Autonomy

Even that statement of the test is inadequate. It fails to fully respect the patient’s autonomy. A better test is to make the treatment decision that follows from the principles and policies that inform the patient’s life and behavior, that is, that explain the behavior and justify and honor it by showing it in the best light. This is another novel suggestion in this context in this article. A person who consistently acts on the basis of the same set of principles and policies acts with integrity, and is in that sense more honorable, and his actions more justified than someone who does not.29

C. Creating Prima Facie Obligations

What properties must a set of principles and policies followed by an individual have in order to impose genuine duties upon him to continue to follow them, and to provide, at least prima facie, a genuine duty to follow them in his future actions?

29 Although my account is original in its application to incapable individuals’ substituted judgments, those familiar with Ronald Dworkin’s theory of law, as laid out in Law’s Empire, will notice the strong analogy. I would nonetheless maintain that my account is preferable and more justified because the concept of individuals acting with integrity by consistently following the same principles is more intelligible than Dworkin’s conception of a legal system personified manifesting integrity by consistently respecting the same principles. Besides being about substituted judgments, not law, our thesis differs from Dworkin’s in two principal respects. It drops his distinction between principles and policies that he never adequately justified. See, e.g. Jules Coleman’s review of Taking Rights Seriously, 66 Cal. L. Rev. 885 (1978). As part of being about substituted judgments, not law, we seek an equilibrium between patient’s beliefs and actions and underlying principles and policies, not legal doctrine and explanatory and justificatory principles.
First, the principles and policies must be reciprocal. That is, other members of the community must follow their own (possibly different) conception of the principle or policy. Second, the obligations purportedly imposed upon the individual must be special, holding within the group, or society, to other members of the group, but not to individuals not part of the group. Third, the duties must be recognized as personal, owed to individual members of the community, and not just to the community as a whole. Fourth, these duties must express a conception of concern, and flow from a more generalized sense of concern each has for the well-being of each of the other members of the community. Fifth, the duties must manifest not only concern for the other members of the community, but equal concern for all members.

Principles and policies that purport to impose responsibilities upon a member of a community that meet the above conditions are, for that reason more justified, and more likely to impose genuine duties that the member has an obligation to obey.

These properties must not be confused with psychological conditions. Although a society will rarely meet or long sustain these conditions unless the members feel an emotional bond with one another, the conditions do not require this to impose genuine prima facie obligations on the members of the group. The required concern is an interpretive property of the society's practices of asserting and acknowledging obligations. Thus, a society that imposes obligations on its members may be larger and more anonymous than a group in which all members have strong emotional
bonds to all other members of the group. Further, the conditions for imposing genuine prima facie obligations on members of the society do not require that the obligations be voluntarily undertaken.

Of course, the prima facie obligations that a society that meets the above conditions imposes can be outweighed, either because the conception of equal concern that they express--even if sincerely believed--is defective because they are unjust to people who are not members of the society.

We may now deepen the argument by considering three accounts of 'principles' that members of a community may purport to follow, and ask which of these accounts best satisfies the conditions we have laid out as essential to imposing true prima facie duties upon its members and thus best legitimizes the responsibilities flowing from those principles. On the first account of principles, persons think the community is merely a de facto accident of history and geography: thus, it does not generate genuine obligations that flow from the principles instinct in the community's official actions. Members of such a community might think of others merely as means to their own selfish ends. But another possibility is that the members are not selfish, but rather deeply committed to their own conception of justice. An official with that view will conceive of his constituents as persons he is in a position to help because of the means of his office. He will regret that he lacks means to help members of other groups.
A second account of community supposes that members of the community do have
genuine obligations to other members of the community. It supposes that persons
accept or negotiate to follow rules, but that the content of the rules exhausts their
obligations. Because the rules represent compromises between opposing
perspectives, it would be unfair to impose obligations beyond the contents of the
rules upon the parties.

A final account of principles takes them seriously, and can appropriately be called
the model of principles. It maintains that the principles that underlie all authorities'
official actions create genuine prima facie duties that the members of a community
must follow when they are not overridden by other considerations of justice,
fairness, or due process. Like the second account, members of a community of
principles accept that prior actions can bind them with obligations to other
members of the community. But unlike the second account, the members of a
community of principles do not hold that they are only bound to the contents of
rules that they have accepted or to which they have negotiated. Rather, they
conceive of themselves as bound to the richer set of obligations that follow from the
principles that underlie and justify their and their officials authoritative actions.

Which of the three attitudes toward principles that members of a community might
take would best satisfy the five conditions prerequisite to creating genuine
obligations and duties. Transparently, the members of a community viewing the
community as a de facto accident of history and geography, and holding that
principles do not generate genuine obligations and duties satisfy none of our five conditions. This model is not a candidate for best satisfying the conditions.

The second account of principles has a better shot at satisfying the five conditions for generating genuine obligations and duties. It concedes that individuals can acquire duties to other members of society as a result of prior authoritative actions and agreements. The account of duties generated by prior authoritative actions is reciprocal, with each individual being obligated to each of the others. Thus, this account meets the first condition for generating genuine duties. Further, the duties are conceived of as special, holding between members of society, but not owed to those not part of the group, thus meeting the second requirement for creating genuine obligations. Additionally, the obligations are individualized, owed from each individual to the others--and not merely to the community as a whole. The second account meets the third condition for generating genuine obligations.

However, the concern that members of this society must show for each other is too shallow to count as the kind of deep concern necessary to generate genuine duties. These individuals are free to manipulate the official apparatus selfishly to further their own ends at the expense of other members of society. They are, as noted, obligated to follow the content of any rules created by prior authoritative actions, but those rules are not restricted in content and thus can fail to manifest the appropriate deep and genuine level of concern. Moreover, even those rules that do
manifest a deep and genuine level of concern may fail to express equal concern and thus fail the fifth condition for creating genuine obligations.

The model of principles community was intentionally constituted to meet the conditions for imposing duties upon its members. The duties imposed upon each member are reciprocal, owed from each member to the others. In such a society the duties are special, owed to other members of the community, but not to those not part of the society. The duties are personal, owed to other members of society, not to society as a whole. Additionally, the duties are deep, genuine and pervasive, expressed by every member's actions arguing about what rules, principles, and policies should be enforced, and which conception of due process, fairness, and justice the authoritative actions of society should exemplify. Finally, the obligations will not only express deep concern for all members, but a conception of equal concern for all. Thus, a society of principles meets all five conditions for imposing genuine prima facie obligations upon its members. It does so better than the other models of society we considered, and is therefore the most legitimate society.

D. Sea Changes in a Patient's Beliefs and Actions

1. Sea Changes in the Substituted Judgment Doctrine

A potentially intractable bone of contention for this theory is sea changes in the patient's beliefs and behavior. The patient joins the Moonies, or leaves the Moonies. Under these circumstances, it might be contended that there are insufficient recent
beliefs and behavior to support a regime of principles and policies. The best rejoinder adopts the patient's current beliefs and behavior as a foundation, and extends the base with those principles and policies that if followed would have the individual leading the best possible life by his own lights, by society's, and objectively speaking (per moro-political theory), thereby honoring the patient. Where extension by principle and policies that best honor the patient is indeterminate, determine the principles and policies by coherence methodology. The importance of acting with integrity and the necessary generality of principles and policies demonstrate the appropriateness of coherence theories of law. Extend what beliefs and behavior you have by adding the best principles and policies consistent with those beliefs and behavior, from which the beliefs and behavior flow. Extend beliefs and behavior by choosing on each issue the best beliefs and behavior that cohere with the current beliefs, behavior, principles, and policies, that constitute a set with maximal implications from principles and policies to beliefs and behavior, and where principles and policies are consistent, as are beliefs and behaviors. Regrettably, a step-by-step coherence methodology is indeterminate. The methodology doesn't determine which beliefs and actions to next extend. As there are a potentially infinite number of beliefs and behaviors to next extend, coherence is infinitely indeterminate. It is also infinitely indeterminate in choosing next principles and policies to consider. Even when a next principle or policy issue has been decided upon, coherence methodology doesn't determine which principle or policy best extends. The same indeterminacy arises respecting beliefs and actions.
Where coherence is indeterminate adopt the best principles and policies consistent with what you have so far. Embracing the best is surely preferable to selecting the worst. Choose the best extensions of beliefs and behaviors.

But if the patient continually goes back and forth between being a member of the Moonies and leaving the Moonies, there may be insufficient consistent beliefs and behavior to support a regime of principles and policies to follow. You--and he--are anchorless. Why not take advantage of it? He should be seen as following and committed to following in the future the best possible principles and policies consistent with some modicum of his best prior behavior.

2. Sea Changes in Dworkin's Legal Philosophy

We should bring these techniques to bear on Dworkin's theory of law, our impetus for this test of substituted judgment. First, however, we should note that all the indeterminacy of step-by-step coherence theories beset Dworkin's theory of law. Because the law changes with new decisions in Dworkin's theory, particularly if the decision was not preordained by prior law, by precedent, retroactive application of law occurs in Dworkin's theory. Cases are decided not by the law existing at the time of the underlying events, but by the law existing at the time of adjudication. Sometimes the law will change between the events and the adjudication so that a litigant who had a right to succeed under the event law will lose under the litigation law. This retroactive application of law occurs when judges correctly enforce changed event rights.
Retroactive enforcement of law is especially problematic for Dworkin because one of his main criticisms of legal positivism is that it countenances retroactive application of law in consequence of judicial discretion. Not all positivist theories countenance retroactive application of law. Positivist theories with closure rules that state that when \( p \) is not required by prior law, precedent, then \( \text{not-}p \) is the law do not require judicial discretion or retroactive application of law. Even those positivist theories that do permit retroactive application of law when judicial discretion is exercised are not afflicted by it as deeply or profoundly as Dworkin's theory is.

When these positivist theories permit retroactive application of law, a novel proposition of law is created and enforced by judicial discretion. The law on this issue was formerly open, so all litigants were on notice that judges might decide the issue either for or against them. Morally, retroactive application of law in such circumstances is not especially troubling. Retroactive application of law in Dworkin's theory appears more problematic. The law was not open, a litigant had a right to win under the event law. Yet litigation law took that right away from him. Retroactivity generated in Dworkin's theory is morally worse than the retroactivity he criticized in positivist theories.\(^{30}\) Sea changes in authoritative legal behavior and

\(^{30}\) Dworkin, stretching, might try to alleviate this situation by claiming that now that it is known that there can be retroactive application of law in his rights thesis, everyone is on notice. So when it occurs, it is not morally troubling. This response does not fly, for several reasons. Retroactivity can occur in the rights thesis with respect to any litigation, any legal proposition. Out of the frying pan, into the fire! This response would completely unsettle law. That is more troubling than Dworkinian retroactivity. Even if Dworkinian retroactivity is now known by a few academics, litigating lawyers, let alone affected clients, aren’t aware of it. Most importantly, Dworkin would never endorse this response. He maintains, as does Susan Hurley, that retroactive application of law only occurs in his theory when judges make intervening decisions that are mistaken. *Ronald Dworkin, Response in 291, 295 Exploring Law's Empire: The Jurisprudence of Ronald Dworkin* (Scott Hershovitz ed. 2006); *S. L. Hurley, Coherence, Hypothetical Cases, and Precedent*, in 69, 100-01,
doctrines are likely to occur less frequently than sea changes in persons. It is easier for one person to radically change beliefs and actions than for all the myriad legal actors to do so in unison. Still, revolutionary change in law is not unheard of. Brown v. Board of Education and its progeny radically changed race relations. Legislatures stepped in, integrating schools in myriad ways, testing to determine which was superior. Neighborhoods were integrated, private cities were integrated, even that bastion not to be interfered with private clubs were integrated. Administrative courts and regulators followed suit. Is anything now segregated? When legal sea changes occur, Dworkin's theory of law must account for it by constructing a fundamentally different set of principles that explain and justify the new law. Mimicking the techniques developed for substituted judgment, we could construct the principles by coherent extensions of the new law and its underlying principles, lacing in the best principles consistent with what else you have when coherence methodology is indeterminate.

III. The Best Interest Principle

Exploring Law's Empire: The Jurisprudence of Ronald Dworkin (Scott Hershovitz ed. 2006). The claim that retroactive application of law occurs in the rights thesis only from mistaken judicial decisions is not the theory of Taking Rights Seriously, which I was explicitly commenting on, nor that in Law's Empire (1985), published mere months subsequent to my first article demonstrating retroactivity in Dworkin's theory of law. Kress, Legal Reasoning and Coherence Theories: Dworkin's Rights Thesis, Retroactivity, and the Linear Order of Decisions, 72 Cal. L. Rev. 369, 377-82 (1984). The mistaken decision diagnosis is a new theory. Hit critical pay dirt in critiquing Dworkin and he makes a distinction and develops a new thesis. Hurley develops the law does not change from correct judicial decisions and diagnosis of retroactivity as due to mistaken intervening judicial decisions in detail in her article, with subtlety, depth, and brilliant creativity. Of course, she thinks she is exploring Dworkin's original published theory. She notes a number of potential ways Dworkin might conceive his theory, or develop his theory. It would be helpful were Dworkin to further weigh in on these issues.
When there is no advance directive, or when it is ambiguous, and there is no applicable substituted judgment, it is generally held that the attending physician or treatment team should provide the treatment that is in the best interest of the patient. The best interest test is complex. It takes into account multiple interests: All of the patient's medical interests, all of his emotional interests, all of his financial interests, all of his interests. It must therefore weigh and balance the interests against one another to determine which treatment and resulting consequent combination of interests and diminishments best advances the patient's welfare overall.

The interest in avoiding serious injury, death, or permanent disability is more important than avoiding the loss of a tooth, or a minor scar. A treatment may support certain interests while frustrating others. A treatment decisionmaker must weigh and balance the interests resulting from each alternative treatment to determine which one produces the greatest net benefit and therefore best serves the patient's welfare overall, or at least serves it well. Producing a net benefit will not justify a treatment under the best interest test--an alternative treatment may produce a larger advantage, although the best interest principle does not require following the maximally beneficial treatment.

The best interest test is patient-centered, focusing on the current and future interests of incapable patients. Whether a treatment is in a patient's best interest hinges upon how it affects his life. Thus, it is largely a quality-of-life determination.
Some courts (ex. Saikewicz\textsuperscript{31}) and the "Baby Doe Regs." have attempted to disallow quality-of-life judgments. This has been criticized as neglecting those lives not worth living because the net deficits outweigh the net benefits. The excluders and their critics almost invariably fail to note a crucial distinction. Interpersonal quality-of-life social comparisons sharply differ from intrapersonal quality-of-life judgments. Interpersonal comparisons are mostly developed in order to permit social decisions on grounds of distributive justice. Giving one patient a scarce resource rather than another is viewed as being more socially valuable, more efficient than providing it to the other. The first patient is more worthy than the second. The intrapersonal best interest judgments are noncomparative. In life-sustaining treatment judgments, they are carefully circumscribed. The issue is not whether the patient's life without the treatment would be worse than most or degraded compared to his life without the treatment. The issue is whether his life without the treatment is worth living and his life with the treatment is not; whether the net advantages over disadvantages without the treatment is positive, yet the net benefits over burdens with the treatment is negative.

The court in \textit{Strunk v. Strunk},\textsuperscript{32} raised the question whether a patient's interest in the good of others is part of the best interest determination. Most such cases involve minors or elderly disabled persons who are potential organ donors for relatives. The relatives urge transplantation because it is in the incapable patient's interest to

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preserve the recipient's life, either to avoid guilt or to preserve a satisfying and supportive relationship. Were a patient's interest in the good of others a constituent of the best interest, there would be an intolerable potential for abuse, even supposing a high threshold of evidence. Yet if sufficiently strong evidence of interest in another's good outweighs the patient's self-interest, the substituted judgment doctrine would have reached the same outcome.

IV. Who Determines the Treatment?

In all these cases there is a need to decide who should determine the treatment. Generally, the family decides, aided by the attending physician. The reason is transparent: the family knows the most about the patient's values and desires; and generally cares the most about the patient while the doctor knows about the medical facts, and the patient's present condition. Yet families should be disenfranchised from decisionmaking when there has been abuse, neglect, or there is a serious conflict of interest. Especial care should be undertaken in circumstances of organ transplants, long-term residence in mental institutions, homes for the mentally challenged, or prisons. Similarly, care must be exercised in any treatment that might result in a reduction in the patient's expected lifespan, or that risks permanent physical or psychological disability. The family's treatment decision must always fall within medically accepted practices in the community as must the patient's under an advance directive, or if he were capable. Determination that the family's authority to decide should be invalidated rests in the first instance with the
attending physician or treatment team, then with the ethics committee, and ultimately resides in the court. If the family employs the best interest principle, they must choose one of the better treatments, but not necessarily the best treatment. That would be too high a standard. Should the family decide on a substituted judgment, that decision should be overridden if it creates a substantial risk of serious harm to the patient, especially if the evidence for the treatment is speculative, more speculative than most substituted judgments, all of which are a reconstruction of the patient's desire if capable.

IV. Severe Mental Illness

A. The First Distinction Between Physical and Mental Illness

The above principles about decisionmaking for those incapable apply to severely mentally ill persons with three possible divergences. The mental illness itself frequently, but not invariably, results in, or constitutes, the incapacity to make treatment decisions. Recent research on lack of insight into one having a mental illness--anosognosia--and the need for treatment demonstrates that over 50% of persons with schizophrenia, active mania, and psychotic depression are substantially impaired in insight.9 Despite pervasive Freudian explanations that lack

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of insight is psychological denial, very few instances can be so classified.\textsuperscript{10} When a Russian dissident, placed in a psychiatric ward denies that he is mentally ill, his denial is justified. Nor can lack of insight be explained by defensiveness, or fear of stigma. \textsuperscript{33} It is most likely that lack of insight is best explained as a neurobiological defect constituted by the unfolding of the disease itself. That is what is meant by saying that lack of insight is a manifestation of the disease itself. It explains why many, who do not blame the disease bearers are tempted not to find fault in their lack of insight.

In the early 1990s, some researchers on lack of insight in schizophrenia noted substantial analogies between anosognosia in neurological patients and those with schizophrenia. In particular, the lack of awareness is severe; it persists despite conflicting evidence; and it is often accompanied by bizarre explanations of the deficits (confabulations), as in neurological patients: "I can’t raise my arm because I have a shirt on."\textsuperscript{34} This led Amador and colleagues in 1991 and 1993 to suggest that

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\textsuperscript{10} AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FOURTH ed. TEXT REVISION 304(AMERICAN PSYCHIATRIC ASSOCIATION 2000)( "A majority of individuals with Schizophrenia have poor insight regarding the fact that they have a psychotic illness. Evidence suggests that poor insight is a manifestation of the illness itself rather than a coping strategy. It may be comparable to the lack of awareness of neurological deficits seen in stroke, termed anosognosia. "); AMADOR, supra note 5, at 35-36 (noting studies demonstrating that neither defensiveness nor fear of stigma explained lack of insight).

\textsuperscript{33} AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FOURTH ed. TEXT REVISION 304(AMERICAN PSYCHIATRIC ASSOCIATION 2000)( "A majority of individuals with Schizophrenia have poor insight regarding the fact that they have a psychotic illness. Evidence suggests that poor insight is a manifestation of the illness itself rather than a coping strategy. It may be comparable to the lack of awareness of neurological deficits seen in stroke, termed anosognosia. "); AMADOR, supra note 5, at 35-36 (noting studies demonstrating that neither defensiveness nor fear of stigma explained lack of insight).

\textsuperscript{34} Amador & Kronefeld, Understanding and Assessing Insight, in INSIGHT, supra note ___3, 23 (hereinafter “Understanding”).
\end{footnotes}
lack of awareness in schizophrenia might be a symptom of a neurological deficit. The suggestion was intriguing, but it lacked empirical support. Empirical support arrived shortly.

Young and colleagues provided the first empirical evidence in a 1993 study. Persons with schizophrenia frequently perform poorly on tests of neuropsychological frontal lobe function, such as executive functioning. If lack of awareness is a symptom of neurological dysfunction, then there should be a substantial correlation between lack of insight and poor performance on neuropsychological tests associated with frontal lobe dysfunction. In 31 chronic patients with schizophrenia, the study by Young and colleagues found a significant correlation between the extent of lack of awareness determined by SUMD, a test of lack of insight developed by Amador and colleagues and two variables on the Wisconsin Card Sorting Test (WCST), a neuropsychological test sensitive to frontal lobe dysfunction. The number of categories completed (p < 0.01) and percentage of perseverative responses (p < 0.05) significantly correlated with SUMD total symptom attribution scores. The number of categories completed (p < 0.001) and the percentage of perseverative responses (p <0.01) significantly correlated with SUMD current awareness of illness scores. The sample was arranged into high and low awareness groups. A discriminant function analysis was performed to detect

36 Young D.A. et al., Unawareness of Illness and Neurological Performance in Chronic Schizophrenia, 10 SCHIZOPHRENIA RESEARCH 117 (1993).
which of a set of variables, including inpatient vs. outpatient status, IQ, WCST categories completed, WCST percentage perseverative responses, and symptom severity most significantly distinguished the high awareness and low awareness groups. The study found that a combination of perseverative errors and average symptom severity correctly categorized 83.9% of the high and low awareness groups.

Since that study, innumerable studies have found correlations between frontal lobe executive dysfunction and poor insight. 37 Morgan and David have reviewed over thirty studies conducted by 2004. 38 One study has not found a significant statistical relationship between lack of insight and frontal lobe dysfunction, but deployed a different measure of insight than the roughly 40 other extant studies have, so it was in fact investigating a different question, and that explains its failure to reach the same conclusion. 39 Moreover, its measure of insight is


38 Kevin D. Morgan & Anthony S. David, Neuropsychological Studies of Insight in Patients with Psychotic Disorders in INSIGHT 177, supra note ____.

not highly regarded.\textsuperscript{40} One study has provided limited support,\textsuperscript{41} another has found a relationship only with particular measures of frontal lobe dysfunction.\textsuperscript{42} The studies that have provided only partial or no support have typically had small sample sizes, with insufficient statistical power to detect the correlations.\textsuperscript{43} However, when 40 studies support a theory, one does not, and two provide partial support, that is overwhelming evidence for the theory.

B. Other Discrepancies from Physical Illness

A second frequently regrettable divergence from the treatment of physical illness is hospitals' tendency to separate decisions about hospitalization from determinations of the appropriate treatment. Some involuntarily hospitalized patients are nonetheless capable of making treatment decisions, including the decision to refuse treatment. This places the treatment team in the position of jailers. The third difference is that an individual committed for danger to others should be treated not primarily for his own sake, as with physical illness, but primarily for the safety of others.

C. Civil Commitment

\textsuperscript{40} Understanding, supra, note\textsuperscript{___} at 25; NOT SICK, supra note\textsuperscript{___}, at 32.
\textsuperscript{41} Smith, T. E., et al., Insight, Symptoms and Neurocognition in Schizophrenia and Schizoaffective Disorder, 26 SCHIZOPHRENIA BULL. 193 (2000) (correlation between insight and attribution of illness rather than awareness of illness, as these terms are deployed in SUMD).
\textsuperscript{42} Drake, R. J. & Lewis, S. W., Insight and Neurocognition in Schizophrenia, 62 SCHIZOPHRENIA RESEARCH 165 (2003).
\textsuperscript{43} Understanding, supra note\textsuperscript{___} at 25; Kevin D. Morgan & Anthony S. David, supra note\textsuperscript{___}.
After the need for treatment criterion for civil commitment was held unconstitutional by the courts, every state enacted a civil commitment statute requiring dangerousness to self or others. Recently, many states have loosened their commitment criteria, permitting commitment for grave disability: the person is unable to satisfy his or her needs for nourishment, clothing, essential medical care or shelter so that it is likely that s/he will suffer physical injury, physical debilitation, or death. Many have recently enacted outpatient commitment statutes, although only half employ them.

An individual committed for dangerousness to others is not entitled to his own treatment decision. He should be treated by one of the means most likely to end his dangerousness to others.

All states by statute now permit commitment upon mental illness and dangerous to self or others. Consider the dangerousness to self criterion. All states require a risk of a substantial harm to self. This reflects the belief that a commitment is a serious restriction of liberty so only a substantial risked harm may justify it. That conceded, the harm needn't be life-threatening or even serious to justify an inpatient

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45 The California Legislature passed the Lanterman-Petris-Short Act by a unanimous vote in 1967, but it did not take effect until 1969. It was officially entitled the California Mental Health Act of 1967 and was included in Division 5 of the California Welfare and Institutions Code. CAL. WELF. & INST. CODE § 36 (West 1967).
commitment. Requiring serious dangerousness misses chronic nondangerous to self schizophrenia and manic-depressives.

D. Refusal to Accept Treatment

Committed patients have refused treatment. Those committed for dangerousness to others should not have a right to refuse. That would frustrate the purpose of the commitment. Three right to refuse cases have reached the U.S. Supreme Court, two on the merits. Patients had argued on constitutional grounds: the 8th Amendment prohibited forced drugging as a cruel and unusual punishment; the first amendment prohibited coerced medication's changing mental processes, it also prohibited unwanted medication as violating freedom of religion; the right to privacy was violated, intrusions into one's thoughts, behavior, personality, and identity were prohibited; the 14th amendment's due process clause prohibited forced medication: absent an emergency, respondents are constitutionally entitled to a hearing, with notice, a written statement of the evidence against him, an opportunity to be heard, cross-examine witnesses, present witnesses, and an independent decision maker. Respondents additionally urged grounds not constitutional in origin: informed consent, exceeding the threshold of coerciveness, overly intrusive, or insufficiently therapeutic.

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In Rogers and Rennie both the trial and appellate courts found a right to refuse treatment, but the U.S. Supreme Court sidestepped that issue. Then in Youngberg v. Romeo, the Court held that patients' only right of review is to determine if the physician exercised "professional judgment."

E. The Least Restrictive Alternative Doctrine

Patients are constitutionally accorded a less restrictive alternative, both to inpatient commitment, for example, outpatient commitment, and to any proposed treatment. They have a right to a less intrusive alternative if it will serve the purposes of the commitment or treatment. Alternatives--especially alternative treatments--satisfy our multiple purposes to varying degrees, and none is overall preferable to all alternatives. One treatment may reduce dangerousness to others the most, yet another reduces dangerousness to self more. A third immediately diminishes mental illness more than either of the first two, yet a fourth maintains a healthy mental state far longer. A fifth produces greater employability than the others, yet a sixth induces better housing than the others. A seventh engenders longer lasting housing. None of these treatments is better than all the rest, or all other potential treatments. The least restrictive alternative is indeterminate; it doesn't get off the ground. This is another fresh insight in the present article.

F. Outpatient Commitment

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Outpatient commitment, generally a court order to accept treatment by medication is currently authorized by statute in 44 jurisdictions although only employed by about half of them. Outpatient commitment is particularly helpful when the patient suffers from anosognosia--neither knows that he is mentally ill nor that his symptoms require treatment. Approximately half of those with mental illness have substantial anosognosia. Outpatient commitment reduces violence and reduces state costs. It also reduces incarceration costs, interactions between police and mentally ill individuals, victimization of mentally ill persons, homelessness, stigma, welfare costs, and suicide.

Outpatient commitment promotes a fairer distribution of scarce mental health resources, increases the quality of life and standard of living of severely mentally ill persons. Furthermore, outpatient commitment improves mental health care services by holding providers accountable, increases the autonomy of persons with mental illness by decreasing their days hospitalized and increasing their days in the community.

48 Ken Kress, An Argument for Assisted Outpatient Treatment for Person with Serious Mental Illness Illustrated with Reference to a Proposed Statute or Iowa, 85 Iowa L. Rev. 1269, 1326-53 (2000)( noting empirical studies finding that outpatient commitment reduced violence by 25%; demonstrating a potential saving of $15.65 million per 1000 persons on outpatient per year in Iowa, a state with roughly 3,000 outpatient commitments at any time).
49 Id. at 1353-61.
50 Id. at 1353-62.
51 Id. at 1364-67.
In summary, this article examines methods of treatment decisionmaking for individuals not capable of making treatment decisions, with an application to seriously mentally ill individuals.