The Statutory Codification of Decisional Capacity Standards

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The adoption of the widely used four specific skills model of decisional capacity assessment, first proposed by Appelbaum and Grisso in 1988, has become widely accepted in clinical practice. Many jurisdictions have, through legislative action, incorporated one or more of these skills into state law as part of the legal definition of decisional capacity. These statutes pose a challenge for physicians hoping to revise these criteria, as some commentators have recently proposed. This article categorizes and analyzes existing state statutes that define decisional capacity or designate certain classes of individuals to render such assessments. Many of these statutes incorporate aspects of the four skills model into state law, such that legislative action would be required to affect significant changes in methods of capacity assessment. As a result, physicians in many jurisdictions are unable to modify these criteria on their own. Any effort to alter capacity assessment standards will have to take into account the potential challenges to enacting statutory change at the outset of such efforts.

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The determination of whether a patient possesses the capacity to make medical decisions has significant implications for individual autonomy and well-being. Until the 1970s, the dominant approaches to medical ethics in the United States emphasized nonmaleficence and beneficence and proved highly paternalistic. The rise of concern for patient autonomy, embodied in the seminal informed consent case of *Canterbury v. Spence* in 1972,[1] led clinicians to propose various mechanisms for determining when patients possess the cognitive capacity to render their own medical choices. These early efforts by Roth *et al.*,[2] Freedman,[3] Sherlock,[4] and Drane[5] culminated in the highly influential article by Appelbaum and Grisso, "Assessing Patients' Capacities to Consent to Treatment,"[6] which has largely shaped clinical practice in the field of decisional capacity in health care in the United States ever since. Among other contributions, Appelbaum and Grisso laid out the four specific skills model, which defined capacity as requiring patients to communicate a clear, consistent choice, appreciate their situation, understand the risk and benefits of proposed interventions, and engage in rational deliberation. The importance of the Appelbaum and Grisso model should not be understated. By emphasizing the need for structured capacity assessment of patients and the determinative value of those assessments on directing patient care, their efforts proved critical to protecting patient autonomy in a manner that placed much of the responsibility for doing so in the hands of their clinicians as opposed to courts or state officials. Although other commentators have contributed additional nuances to this approach (most notably Buchanan and Brock's emphasis on the "decision relative" nature of capacity[7]), until very recently the fundamental underpinnings of the four skills approach have gone largely unchallenged. In fact, as discussed in this article, many jurisdictions have codified aspects of the four skills approach into law.

In the 1980s, implementing novel approaches to decisional capacity assessment was largely a matter for clinicians in the field, limited, to some degree, by the occasional court ruling and perceptions of the standard of care. Since that time, both the criteria for decisional capacity and the process for determining capacity have been formally codified in many jurisdictions. As a result, even small changes to practice may require legislative action. In some jurisdictions, this codification denies physicians the flexibility to

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implement values-based approaches to decisional capacity assessment or to experiment with the alternative approaches suggested in the literature. This article offers several situations that might justify such modification, although a detailed discussion of the arguments for reform is beyond its scope. Rather, the purpose of this article is to offer a review and analysis of the current legal framework so that potential reformers know where such flexibility exists and where reform would require legislative action. Whether criteria for capacity assessment should be codified into law at all, or should be left to professional discretion and standards of care, is also a question worth future consideration, although one not explored in this article.

For clinicians, especially practitioners of consult–liaison psychiatry and forensic-trained examiners, to advocate for reforms, they must be aware of existing laws. They may also benefit from understanding the range of approaches to capacity that state legislatures have been willing to adopt. This article briefly reviews recent challenges to the four skills model of decisional capacity assessment and then catalogues and classifies state statutes related to capacity assessment that have been adopted since the publication of the Appelbaum and Grisso landmark article. In doing so, the goal is to highlight both the influence of that rubric on current legal standards and the challenge that reformers may face.

Recent Critiques of the Four Skills Method

Two sets of challenges have arisen in recent years that have questioned aspects of the four skills approach. One focuses on its application and, particularly, the potential negative consequences that stem from the confrontational nature of the "capacity challenge" itself.[8,9] Historically, many clinicians have thought of capacity assessment as a clinical tool. Recent commentators have suggested that it might better be thought of as an intervention with potential risks and negative consequences.[8] The questioning of a patient's ability to render health care decisions can generate distress and prove disruptive to the therapeutic process. In addition, many capacity assessments are conducted by psychiatrists (a statutory requirement in some jurisdictions) and, as Talukdar saliently notes, "a number of patients may harbor apprehensions or misconceptions about psychiatrists, reinforced by the stigma that persists against the specialty and its practitioners" (Ref. 9, p 6). Such an impact may prove particularly deleterious for members of marginalized communities who may enter the medical setting with historically justified reasons to distrust medical professionals. In fact, Garrett *et al.*[10] have reported significant racial bias in the outcomes of capacity assessments. In particular, they note that Black and Hispanic patients are subject to "capacity assessments requested by primary consulting medical teams at a disproportionately high rate in relation to the overall racial demographic composition of admitted hospital inpatients" and that a significant portion of these consults turn out to be "irrelevant" to management (Ref. 10, p 14).

A second set of challenges has focused on the expansion of the four skills model beyond the scope of cases for which it was originally designed. The original criteria were designed for patients who once possessed decisional capacity but, as a result of medical or psychiatric impairment, had lost that ability. But the criteria have increasingly been applied to patients whose underlying, long-term values or acceptance of science are simply not in accord with those of allopathic medicine. For example, the Appelbaum and Grisso criteria treat in the same manner (and likely arrive at the same conclusion for) a patient with a life-threatening condition who doubts the efficacy of highly effective allopathic medicine under all circumstances, despite empirical evidence, whether the patient's doubts stem from a potentially reversible psychotic delusion or from a longstanding, deeply held, but false, belief about the legitimacy of science. Similarly, a cancer patient objecting to chemotherapy as a result of cognitive impairment and one objecting as a result of adaptive denial of the diagnosis (*i.e.*, denial intended to protect the patient from being emotionally overwhelmed or paralyzed by bad news) prove difficult to distinguish. In some cases, current practice extends beyond the bounds overtly discussed in the Appelbaum and Grisso article. They note, for instance, that it is "clearly wrong"[6] to conclude that patients who willfully refuse to communicate a choice lack capacity to do so, yet many practitioners now use their model to achieve precisely this conclusion.[11]

Over the past decade, critics starting with Banner and Szmukler[12] have argued that traditional models of assessment fail to seriously consider patients' underlying values. These arguments build on earlier criticisms that argue the four skills model overvalues cognitive

skills.[13] More recently, I have argued for a method that explores differences between the preferences of the patient at present and the patient's baseline values.[14] None of these approaches rejects the merits of the four skills approach in its entirety. Rather, they emphasize the need for additional modifications and safeguards, especially the incorporation of these skills into a larger, more collaborative, and values-based framework for evaluation.[15]

The Codification of Capacity Statutes

History of State Capacity Statutes

Formal definitions of capacity first arose in the nonmedical setting in relation to such matters as writing wills (testamentary capacity), testifying in court (testimonial capacity), and signing commercial contracts. In the United States, these definitions initially emerged through the common law in such seminal cases as *Harrison v. Rowan* in 1820[16] and *Betts v. Jackson ex rel. Brown* in 1830.[17] Physicians were often called on to testify in these early cases and, over time, proposed tests and definitions of their own.[18] The rise of health care ethics in which patients had authority over their own medical decisions led to the emergence of clinical standards that shaped judicial decisions and, in turn, to legislative efforts to codify these standards in the 1970s.[19,20] Yet the definition of capacity went largely unaddressed in these early statutes, leaving wide discretion to physicians and the judiciary.[21] The first state legislative attempt to define decisional capacity specifically for health care occurred in Idaho,[22] which in 1977 imposed a very broad "comprehensibility standard" for physicians evaluating a patient's capacity to offer informed consent.[23] This approach allowed a patient to consent to care if the physician deemed the patient to have sufficient "intelligence and awareness" to do so.[24] Yet it was not until the 1990s that state legislatures began to grapple with defining decisional capacity on a wider scale. In 1993, the National Conference of Commissioners on Uniform State Laws, a nonprofit legal organization that drafts model laws which states may enact, modify, or ignore, proposed a Uniform Health-Care Decisions Act (UHCDA) for potential adoption in all 50 states that defined "capacity" for the purposes of health care decisions as "an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision" (Ref. 25, p 85). The influence of Appelbaum and Grisso is readily apparent. By the time the Uniform Law Commissioners proposed the UHCDA, many states had already adopted statutes on third-party decision-making, some without definitions of capacity. As English noted, "[c]onvincing states to revisit existing legislation is not easy" (Ref. 26, p 20). At present, only seven American jurisdictions (Alaska, Delaware, Hawaii, Maine, New Mexico, Mississippi, and Wyoming) have adopted the proposed Uniform Law Commission statute, although a few others have enacted similar laws or have adopted definitions of capacity derived from the UHCDA.[27] Not all of the states adopting modified versions of the UHCDA have included the UHCDA's definition of capacity. In comparison, states have generally been early adopters of other model statutes; the Uniform Determination of Death Act, for instance, was adopted by 38 jurisdictions in its first 37 years.[28] Instead of embracing the UHCDA criteria, some states have proposed their own definitions, some influenced to some degree by Appelbaum and Grisso. Others have left the definition of capacity to the courts or entirely to physicians in the field. The result is a highly variegated patchwork of legislative regulation.

Current Laws

At present, 41 states and the District of Columbia define decisional capacity by statute (although, of note, several still use the terms "competence" or "incompetence"), whereas nine American jurisdictions do not (see Table 1). A number of these jurisdictions only define capacity in the context of advance directives, so whether or not the same standards apply to surrogate decision-making remains unclear. In addition, states may have supplemental administrative guidelines that either codify court decisions or fill in the gaps in legislation, a subject which is beyond the scope of this article. Many of the state statutory definitions share commonalities that help divide them into categories. Two particular such classifications may prove useful to psychiatrists interested in reforming existing approaches.

First, one might classify these statutes based on the degree to which they incorporate the four skills model. Of the 42 jurisdictions that codify definitions of capacity, 10 include three or four of the Appelbaum and Grisso criteria, 23 include two of the Appelbaum and Grisso criteria, and six include

Table 1 Medical Capacity Definitions and Deciding Parties by State

State	Medical Capacity Defined by Statute	Definition	Deciding Party Specified by Statute	Other Applications or Limitations
Alabama	YES	"Competent Adult. An adult who is alert, capable of understanding a lay description of medical procedures and able to appreciate the consequences of providing, withholding, or withdrawing medical procedures."[29]	YES[30]	N/A
Alaska	NO	N/A	NO	Courts; Defined for guardianship purposes only. "'incapacitated person' means a person whose ability to receive and evaluate information or to communicate decisions is impaired for reasons other than minority to the extent that the person lacks the ability to provide the essential requirements for the person's physical health or safety without court-ordered assistance."[31]
Arizona	YES	"Unable to make or communicate health care treatment decisions"[32]	NO	N/A
Arkansas	YES	"'Capacity' means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a healthcare decision"[33]	YES[34]	N/A
California	YES	"'Capacity' means a person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives."[35]	YES[36]	Statute favors extrajudicial decision-making: "In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment."[37]
Colorado	YES	"'Decisional capacity' means the ability to provide informed consent to or refusal of medical treatment or the ability to make an informed health care benefit decision."[38]	NO[39]	Defined in context of statute on advance directives; broader applicability uncertain.[38]
Connecticut	YES	"'Incapacitated' means being unable to understand and appreciate the nature and consequences of health care decisions, including the benefits and disadvantages of such treatment, and to reach and communicate an informed decision regarding the treatment"[40]	NO	Defined in context of statute on advance directives; broader applicability uncertain.[40]
Delaware	YES	"'Capacity' shall mean an individual's ability to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health-care decision."[41]	YES[42]	N/A
District of Columbia	YES	"Incapacitated individual means an adult individual who lacks sufficient mental capacity to appreciate the nature and implications of a health-care decision, make a choice regarding the	YES[44]	N/A

Table 1 Continued

State	Medical Capacity Defined by Statute	Definition	Deciding Party Specified by Statute	Other Applications or Limitations
		alternatives presented or communicate that choice in an unambiguous manner."[43]		
Florida	YES	"Incapacity or incompetent means the patient is physically or mentally unable to communicate a willful and knowing health care decision."[45]	YES[46]	N/A
Georgia	YES	In context of cardiopulmonary resuscitation; unclear if definition applies elsewhere: "'Decision-making capacity' means the ability to understand and appreciate the nature and consequences of an order not to resuscitate, including the benefits and disadvantages of such an order, and to reach an informed decision regarding the order."[47] Elsewhere, an incapacitated person is defined as an adult who "lacks sufficient understanding or capacity to make significant responsible decisions regarding his or her medical treatment or the ability to communicate by any means such decisions."[48]	YES[48]	N/A
Hawaii	YES	"'Capacity' means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision."[49]	YES[50]	N/A
Idaho	YES	"'Decisional capacity' means the ability to provide informed consent to or refusal of medical treatment."[51]	NO	N/A
Illinois	YES	"'Decisional capacity' means the ability to understand and appreciate the nature and consequences of a decision regarding medical treatment or forgoing life-sustaining treatment and the ability to reach and communicate an informed decision in the matter as determined by the attending physician."[52]	YES[52]	N/A
Indiana	YES	"'incapacity' and 'incapacitated' mean that an individual is unable to comprehend and weigh relevant information and to make and communicate a reasoned health care decision"[53]	YES[54]	N/A
Iowa	NO	N/A	NO	N/A
Kansas	NO	N/A	NO	N/A
Kentucky	YES	"'Decisional capacity' means the ability to make and communicate a health care decision"[55]	YES[56]	N/A
Louisiana	YES	"Capacity to give consent or make a particular decision exists when a person is able to comprehend the purposes, consequences, risks and benefits of the decision and any available alternatives." Limited to cases of patients with "cognitive disabilities."[57]	NO	N/A

Table 1 Continued

State	Medical Capacity Defined by Statute	Definition	Deciding Party Specified by Statute	Other Applications or Limitations
Maine	YES	"'Capacity' means the ability to have a basic understanding of the diagnosed condition and to understand the significant benefits, risks and alternatives to the proposed health care and the consequences of forgoing the proposed treatment, the ability to make and communicate a health care decision and the ability to understand the consequences of designating an agent or surrogate to make health care decisions."[58]	YES[59]	N/A
Maryland	YES	"'Competent individual' means a person who is at least 18 years of age or who under § 20–102(a) of this article has the same capacity as an adult to consent to medical treatment and who has not been determined to be incapable of making an informed decision."; "'Incapable of making an informed decision' means the inability of an adult patient to make an informed decision about the provision, withholding, or withdrawal of a specific medical treatment or course of treatment because the patient is unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, is unable to make a rational evaluation of the burdens, risks, and benefits of the treatment or course of treatment, or is unable to communicate a decision."[60]	YES[61]	Defined in context of statute on advance directives; broader applicability uncertain.[61]
Massachusetts	YES	"Capacity to make health care decisions" is defined as "the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision."[62]	YES[62]	N/A
Michigan	NO	N/A	NO	Michigan does define "incapacitated individual" in detail in its probate code as "an individual who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, not including minority, to the extent of lacking sufficient understanding or capacity to make or communicate informed decisions." Not clear to what degree this binds clinicians, although it certainly offers guidance.[63]

Table 1 Continued

State	Medical Capacity Defined by Statute	Definition	Deciding Party Specified by Statute	Other Applications or Limitations
Minnesota	YES	"'Decision-making capacity' means the ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision."[64]	YES[65]	N/A
Mississippi	YES	"'Capacity' means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision."[66]	YES[67]	N/A
Missouri	YES	"Incapacitated" is defined as "a person who is unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions to such an extent that he lacks capacity to meet essential requirements for food, clothing, shelter, safety or other care such that serious physical injury, illness or disease is likely to occur"[68]	YES[69]	Defined in context of statute on advance directives; broader applicability uncertain.[68]
Montana	YES	"'Decisional capacity' means the ability to provide informed consent to or refuse medical treatment or the ability to make an informed health care decision as determined by a health care provider experienced in this type of assessment."[70]	YES[71]	N/A
Nebraska	YES	"Capable means (a) able to understand and appreciate the nature and consequences of a proposed health care decision, including the benefits of, risks of, and alternatives to any proposed health care, and (b) able to communicate in any manner such health care decision"[72]	YES[73,74]	N/A
Nevada	NO	N/A	NO	Nevada does define incapacity specifically for psychiatric advance directives as when a "person currently lacks sufficient understanding or capacity to make or communicate decisions regarding psychiatric care" and in these limited cases specifies that the determination must be made by "two providers of health care, one of whom must be a physician or licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing."[75]

Table 1 Continued

State	Medical Capacity Defined by Statute	Definition	Deciding Party Specified by Statute	Other Applications or Limitations
New Hampshire	YES	"'Capacity to make health care decisions' means the ability to understand and appreciate generally the nature and consequences of a health care decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care. The fact that a person has been diagnosed with mental illness, brain injury, or intellectual disability shall not mean that the person necessarily lacks the capacity to make health care decisions."[76]	YES[77]	N/A
New Jersey	YES	"'Decision making capacity' means an individual's ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of each, and alternatives to any proposed health care, and to reach an informed decision on his or her own behalf."[78]	YES[79]	N/A
New Mexico	YES	"'Capacity' means an individual's ability to understand and appreciate the nature and consequences of proposed health care, including its significant benefits, risks and alternatives to proposed health care and to make and communicate an informed health-care decision."[80]	YES[81]	N/A
New York	YES	"'Decision-making capacity' means the ability to understand and appreciate the nature and consequences of proposed health care, including the benefits and risks of and alternatives to proposed health care, and to reach an informed decision."[82]	YES[83,84]	N/A
North Carolina	NO	N/A	YES[85]	Process applies in context of statute on advance directives; broader applicability uncertain.[85]
North Dakota	YES	"'Capacity to make health care decisions' means the ability to understand and appreciate the nature and consequences of a health care decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care, and the ability to communicate a health care decision."[86]	YES[87]	N/A
Ohio	NO	N/A	YES[88,89]	
Oklahoma	YES	"persistently unconscious, incompetent or otherwise mentally or physically incapable of communicating"[90]	YES[91]	Defined in context of statute on advance directives; broader applicability uncertain.[90]
Oregon	YES	"'Incapable' means that in the opinion of the court in a proceeding to appoint or confirm authority of a health care representative, or in the opinion of the principal's attending physician or	YES[92]	N/A

Table 1 Continued

State	Medical Capacity Defined by Statute	Definition	Deciding Party Specified by Statute	Other Applications or Limitations
		attending health care provider, a principal lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available."[92]		
Pennsylvania	YES	Competent, which appears to be synonymous with capacitated in Pennsylvania, is defined as a "condition in which an individual, when provided appropriate medical information, communication supports and technical assistance, is documented by a health care provider to do all of the following: (1) Understand the potential material benefits, risks and alternatives involved in a specific proposed health care decision. (2) Make that health care decision on his own behalf. (3) Communicate that health care decision to any other person. This term is intended to permit individuals to be found competent to make some health care decisions, but incompetent to make others."[93]	YES[93]	N/A
Rhode Island	NO	N/A	NO	N/A
South Carolina	YES	"'Unable to consent' means unable to appreciate the nature and implications of the patient's condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This term does not apply to minors, and this chapter does not affect the delivery of health care to minors unless they are married or have been determined judicially to be emancipated."[94]	YES[94]	Minors excluded from process.[94]
South Dakota	NO	N/A	YES[95]	N/A
Tennessee	YES	"'Capacity' means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision."[96]	YES[97]	N/A
Texas	YES	"'Incapacitated' means lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decision."[98]	YES[99]	N/A

Table 1 Continued

State	Medical Capacity Defined by Statute	Definition	Deciding Party Specified by Statute	Other Applications or Limitations
Utah	YES	"'Health care decision making capacity' means an adult's ability to make an informed decision about receiving or refusing health care, including: (a) the ability to understand the nature, extent, or probable consequences of health status and health care alternatives; (b) the ability to make a rational evaluation of the burdens, risks, benefits, and alternatives of accepting or rejecting health care; and (c) the ability to communicate a decision."[100]	YES[101]	N/A
Vermont	YES	"'Capacity' means an individual's ability to make and communicate a decision regarding the issue that needs to be decided. . . .An individual shall be deemed to have capacity to make a health care decision if the individual has a basic understanding of the diagnosed condition and the benefits, risks, and alternatives to the proposed health care."[102]	YES[103]	N/A
Virginia	YES	"'Incapable of making an informed decision' means the inability of an adult patient, because of mental illness, mental retardation, or any other mental or physical disorder which precludes communication or impairs judgment"[104]	YES[105]	N/A
Washington	YES	Incapacity defined as "demonstrated inability to understand and appreciate the nature and consequences of a health condition, the proposed treatment, including the anticipated results, benefits, risks, and alternatives to the proposed treatment, including nontreatment, and reach an informed decision as a result of cognitive impairment"[106]	YES[106]	N/A
West Virginia	YES	"'Capable adult' means an adult who is physically and mentally capable of making health care decisions" (excluding certain protected individuals); "'Incapacity' means the inability because of physical or mental impairment to appreciate the nature and implications of a health care decision, to make an informed choice regarding the alternatives presented, and to communicate that choice in an unambiguous manner."[107]	YES[108]	N/A
Wisconsin	YES	"'Incapacity' means the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions."[109]	YES[110]	Defined in context of statute on advance directives; broader applicability uncertain.[110]

Table 1 Continued

State	Medical Capacity Defined by Statute	Definition	Deciding Party Specified by Statute	Other Applications or Limitations
Wyoming	YES	"'Capacity' means an individual's ability to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health care decision"[111]	YES[112]	Defined in context of statute on advance directives; broader applicability uncertain.[111]

Table 2 Statutory Codification of Appelbaum and Grisso Criteria by State

States that require three to four Appelbaum and Grisso criteria by statute (10):
California, Connecticut, District of Columbia, Maine, Maryland, Nebraska, New Mexico, North Dakota, South Carolina, Utah
States that require two Appelbaum and Grisso criteria by statute (23):
Alabama, Arkansas, Delaware, Georgia, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, Pennsylvania, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, Wyoming
States that require one Appelbaum and Grisso criterion by statute (6):
Arizona, Florida, Kentucky, Oklahoma, Oregon, Virginia
States that define capacity but require no Appelbaum & Grisso criteria (3):
Colorado, Idaho, Montana

one of the Appelbaum and Grisso criteria. Three jurisdictions that define capacity by statute do not incorporate any of the Appelbaum and Grisso criteria (see Table 2). The most common criteria met is communicating a choice, which is part of the statutory definition in 30 jurisdictions. In contrast, only a small number of states either explicitly require rational or reasoned thinking (South Carolina, Utah) or do so implicitly with terms like "knowing" and "informed" (New Jersey, Washington, West Virginia).

Second, one might classify states into those where significant reforms to decisional capacity assessment would require legislative action and those where either no statutory definition exists or the definition is so broad (e.g., ability to make an informed decision) as to permit a wide range of interpretations and practices. In general, those that rely on Appelbaum and Grisso are too precise to permit significant leeway to clinicians. Because many different reforms to the existing model are possible, identifying specific intended reforms for such analysis is necessary; as an example, this article uses the proposed alternative of a value-based model, which narrows the application of the four skills model and downplays the importance of reasoned explanation in the evaluation process.[14] Such recently proposed reform emphasizes a comparison of the patient's current wishes with the patient's known values and accepts those wishes if they are concordant with known previously held values even if the patient is presently unable to understand the risks and benefits of proposed intervention or to engage in rational deliberation.[14] It is important to note that this is not the only possible reform one might choose as a reference and that a range of other approaches is possible.[15] To adopt such an approach, clinicians in 32 American jurisdictions would have to pursue legislative change. In contrast, such reforms could be implemented without legislative action in 19 states either because no statute currently defines capacity or the statute defines capacity in very broad terms that allow evaluators considerable latitude in method of assessment (see Table 3).

Another related feature of these laws is to whom they assign decisional authority over capacity; this aspect of the statutes is relevant because clinicians must have the authority to assess capacity if they intend to reform capacity standards. At present, 39 American jurisdictions have statutes that overtly clarify who may decide whether or not a patient has decisional capacity, and 12 do not (see Table 1). Of those 39 jurisdictions that determine the evaluator by statute, nearly all place the decision in the hands of a clinical provider, although three also allow for direct determination by the courts (see online Appendix). Twenty-nine require only one clinician, six require two clinicians, two (Maryland and South Carolina) require one or two depending on the precise circumstances, and one (New York) generally requires one but may require confirmation of a second for certain patients

Table 3 State Statutes and Values-based Capacity Assessment

States where legislative action would be required to adopt a values-based approach to capacity assessment (32):
Alabama, Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New York, New Mexico, North Dakota, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wyoming
States where legislative action would not be required to adopt a values-based approach to capacity assessment (19):
Alaska, Arizona, Colorado, Florida, Idaho, Iowa, Kansas, Kentucky, Michigan, Montana, Nevada, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Virginia, Wisconsin

with developmental delay. All of these jurisdictions allow physicians to render such decisions, but several states also permit other disciplines, including nurse practitioners, physician assistants, and psychologists (see online Appendix). The importance of this authority is that in all jurisdictions where legislative action is not required, physicians may be empowered to enact reforms on their own. But the widespread acceptance of certain parameters as standards of care over the past three decades may, in practice, also limit the scope of such potential actions. At the same time, despite predictions that evaluators might be sued for negligent decisional capacity assessment, few if any such cases have yet arisen and malpractice parameters in this area remain largely untested.[113] Needless to say, psychiatrists should consult their hospitals' legal departments before deviating significantly from established norms.

Significance

Beyond setting out four skills necessary to define capacity, the Appelbaum and Grisso[6] approach championed the authority of patients endowed with these skills to direct their own health care and the role of physicians in rendering such determinations. These reforms marked a highly valuable shift away from approaches of the previous era in which physicians often rendered clinical decisions on behalf of patients in the name of beneficence. What is often lost in discussions of the influence of Appelbaum and Grisso is how readily their approach became widely adopted.

One of the likely explanations for the speed at which the four skills model became widespread practice was the absence of legal barriers to implementing it. In the late 1980s, only a few states had attempted to define clinical capacity either legislatively or through the courts, rather than deferring to physicians on a case-by-case basis, so adopting a relatively novel approach to meet a clinical need faced minimal resistance from outside of medicine. The very absence of clear professional standards at the time created a void which made the appearance of an easily operationalizable set of such guidelines highly appealing to clinicians in the field. Much of this occurred without political notice. One might reasonably speculate that most state legislators in the late 1980s and early 1990s were unaware that the four skills model was being adopted by physicians at hospitals within their jurisdictions.

In contrast, the four skills model is now the most commonly used method of capacity evaluation in the United States, is taught in medical schools across the nation, and is even incorporated into the American Psychiatric Association's resource document on the subject.[114] It is arguably the standard of care. Nonetheless, other modified approaches do have backing in the literature and might qualify as acceptable alternative practices under the respectable minority doctrine, a legal rule that shields practitioners from malpractice liability for innovative and dissenting approaches to care that reflect positions advocated by a meaningful number of thought leaders in the profession.[115] In jurisdictions that have codified aspects of the four skills model into law, however, physicians are not at liberty to engage in such reforms on their own. The legal landscape is far different from what it was in 1988 when Appelbaum and Grisso published their article. At present, in most jurisdictions, a legislative change would need to precede any such action. Such changes might include either modifying statutes to more flexible language that would permit methods that embrace proposed reforms, such as values-based assessment models, or legislation to remove the definition of clinical capacity from state codes in favor of returning the criteria entirely to physicians' standards of care, as was the case before the 1980s.

Conclusions

The four skills model had a transformative effect on the evaluation of decisional capacity in the clinical setting when it first appeared in the late 1980s and continues to be the dominant mechanism for such

determinations. Few, if any, commentators suggest abandoning this approach in its entirety. Rather, a number of commentators have suggested alternative approaches that incorporate many aspects of the four skills model, but in a manner that emphasizes prior values and deemphasizes rational engagement. Such efforts may prove an uphill challenge because the four skills model has been incorporated into law in many jurisdictions. That leaves reformers with two viable courses of action: either working toward revised legislation in the majority of states where such statutes already exist or focusing their efforts on the remaining minority of states where the definition of capacity remains defined either by custom and practice or by extremely broad statutory definitions. In either case, familiarity with the existing scheme of statutory regulation is an essential first step.

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