"DIMINISHED CAPACITY"—YOU KNOW IT WHEN YOU REASONABLY BELIEVE IT?:

TOWARDS AN ETHICAL OBLIGATION FOR LAWYERS TO RECOGNIZE THE DECISION-MAKING SUPPORTS OF PERSONS WITH INTELLECTUAL & PSYCHO-SOCIAL DISABILITIES

———

Matthew S. Smith

Robert D. Reif Fellowship in Legal Ethics and Professional Values

August 30, 2013

TABLE OF CONTENTS

I. INTRODUCTION 2
II. THE DECISION-MAKING PARADIGM SHIFT 4
A. Shift Towards Universal Capacity 5
B. Out with the Normal, In with the Diverse 7
C. Away from the (Dys)Functional Approach 9
III. THE MODEL RULES' RESPONSE TO PERECEIVED DIMINISHED DECISION-MAKING CAPACITY 11
A. You Know It When You Reasonably Believe It 12
B. Situation Normal, All Modeled Up 13
C. Every Man Is an Island? 16
IV. RECOMMENDED MODIFICATIONS TO THE MODEL RULES 19
A. Rule 1.14(a) Should Instruct Lawyers to Assess a Client's Supported, Rather Than Individual Capacity 19
B. Rule 1.14(b) Should Require Recourse to Informal Decision-Making Supports Before Taking a Protective Actions 20
C. Comment 3 Should Encourage Lawyers to Recognize and Avail of Legitimate Decision-Making Supports 21
V. CONCLUSION 22

I. INTRODUCTION

In October 2012, the American Bar Association (ABA) Commission on Law and Aging partnered with the ABA Commission on Disability Rights and the U.S. Administration on Intellectual and Developmental Disabilities to organize a pioneering roundtable discussion entitled "Beyond Guardianship: Supported Decision-Making by Individuals with Intellectual Disabilities."[1] The Roundtable, which brought together self-advocates, members of the judiciary, advocacy groups, family members, service providers, and government agencies, aimed to look beyond the current guardianship model to empower and support the decision-making of the growing population of individuals with intellectual disabilities.[2] The Roundtable was spurred by the rising movement in favor of "supported decision-making," sustained by the United Nations Convention on the Rights of Persons with Disabilities (CRPD).[3]

Article 12(2) of the CRPD requires that "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."[4] Article 12(3) specifies further that "States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."[5] The "support" envisioned in Article 12(3) is frequently described as "decision-making supports,"

---

[1] ABA Comm'n on L. & Aging, *Guardianship and Capacity Issues*, 34(2) BIFOCAL 32 (Nov.-Dec. 2012), *available at* http://www.americanbar.org/publications/bifocal/vol_34/issue_2_dec2012/guardianship_and_capacity_issues.html. Similarly, on April 10, 2013, the Disability Law Society, together with the Office of Public Interest and the International Legal Studies Program of the Washington College of Law, organized a panel on "Clients with Intellectual Disabilities: Ethical and Rights-Based Considerations for Private and Public Practitioners," where panelists agreed on the need to revise Model Rules of Professional Conduct 1.14.

[2] *See* ABA Comm'n on L. & Aging, *supra* note 1.

[3] *See id.*; United Nations Convention on the Rights of Persons with Disabilities [hereinafter, "CRPD"], S. TREATY DOC. No. 112-7, 2515 U.N.T.S. 3 (adopted Dec. 13, 2006) (entered into force May 3, 2008) (signed by the United States on July 30, 2009) (vote for ratification failed in the Senate on Dec. 5, 2012).

[4] *Id.* at. art. 12(2).

[5] *Id.* at. art. 12(3).

which characterize the "supported decision-making model."[6] This model contrasts with the "substitute decision-making model," which permits authorizing third persons, such as guardians, to realize legal acts on behalf of persons with disabilities, generally with no legal obligation to consult with them or adhere to their opinions.

In the United States, supported decision-making exists (if at all) as a guiding principle within substitute decision-making frameworks, but such progressive implementation of substitute decision-making norms is neither systematic nor well-documented.[7] While not the only reason, one obstacle to promoting supported decision-making practices in the United States may be found in Rule 1.14 of the Model Rules of Professional Conduct (hereinafter, "Model Rules") on "Client with Diminished Capacity."[8] While revisions to Model Rule 1.14 may have helped to challenge notions of normalcy in decision-making capacity and to recognize that there exist varying degrees of capacity, they ultimately fall short of encouraging lawyers to embrace the supported decision-making model.[9] If supported decision-making practices are to gain footing within the United States, the Model Rules must include a workable, ethical obligation for lawyers to recognize them.

This paper aims to analyze Rule 1.14 from the perspective of supported decision-making and to discuss possible avenues for bringing Rule 1.14 closer into alignment with supported decision-making's underlying ideas. Part II fleshes out in greater detail the principles that

---

[6] *See generally* Janet E. Lord & Michael A. Stein, *Contingent Participation and Coercive Care: Feminist and Communitarian Theories Consider Disability and Legal Capacity, in* COERCIVE CARE: RIGHTS, LAW AND POLICY 31 (Bernadette McSherry & Ian Freckelton eds., 2013).

[7] *See* A. Frank Johns, *Person-Centered Planning in Guardianship: A Little Hope for the Future*, 2012 UTAH L. REV. 1541 (2012) (describing person-centered planning practices as the most viable alternative in the United States for shifting away from substitute decision-making).

[8] MODEL RULES OF PROFESSIONAL CONDUCT 1.14 (2012) [hereinafter, "MODEL RULES"].

[9] Prior to the amendment effective as of January 1, 2008, Rule 1.14 had a lower threshold for protective action, stating that such action could be taken "only when the lawyer reasonably believes that the client cannot act in the client's own interest." *See* Bernard A. Poskus, *Rule of Professional Conduct 1.14 and the Diminished-Capacity Client*, 39 COLO. LAW. 67, 70 (2010).

characterize the supported decision-making model enshrined in the CRPD. Part III discusses how Rule 1.14 fails to reflect accurately the ways in which persons with (and without) disabilities make decisions generally. Part IV proposes textual revisions to Rule 1.14 designed to promote lawyers' awareness of the emerging paradigm shift. Part V concludes by offering some reflections on the larger social importance of lawyers' role in facilitating supported decision-making by persons with disabilities, thereby promoting their great social inclusion.

II. THE DECISION-MAKING PARADIGM SHIFT

In the United States, where the obligations contained in the CRPD are not legally binding, no jurisdiction formally recognizes supported decision-making arrangements.[10] Nevertheless, even in jurisdictions not legally bound by the CRPD, it has already "trigger[ed] belief changes . . . with the attendant effect of serving as [an] educational tool[] for altering social mores."[11] Indeed, some proponents have introduced CRPD-inspired ideas and interpretations into domestic legal proceedings.[12] Moreover, the CRPD's decision-making paradigm shift has implications for the norms governing lawyer–client relationships, described in the following sections, specifically insofar as it promotes the value of diversity, undermines the "functional approach" to capacity, and implies respect for the capacity of persons with disabilities viewed together with decision-making supports.

---

[10] By contrast, in some Canadian provinces, persons with disabilities have the right to enter into a private legal agreement with one or more persons of his choosing who will provide assistance with decision making or act as his formal decision-making representative(s). *See* Leslie Salzman, *Guardianship for Persons with Mental Illness—A Legal and Appropriate Alternative?*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 279, 307-10 (2011).

[11] Janet E. Lord & Michael A. Stein, *The Domestic Incorporation of Human Rights Law and the United Nations Convention on the Rights of Persons with Disabilities*, 83 WASH. L. REV. 449, 474-75 (2008) (describing generally the ways in which the CRPD facilitates the transformation of domestic social and legal norms).

[12] *See, e.g.*, *In re Guardianship of Dameris L.*, 956 N.Y.S.2d 848, 853 (N.Y. Cnty. Surr. Ct. 2012) (observing that supported decision-making, rather than substitute decision-making, was consistent with the object and purpose of the CRPD); *In re SCPA Article 17-A Guardianship Proceeding for Mark C.H., Ward*, 906 N.Y.S.2d 419, 433 (N.Y. Cnty. Surr. Ct. 2010) (remarkably interpreting treaty signatories' obligation under international law not to derogate from a treaty's object and purpose to prevent the imposition of a plenary legal capacity restriction).

A. SHIFT TOWARDS UNIVERSAL CAPACITY

The CRPD is widely understood to promote a "paradigm shift" away from the substitute decision-making model, in favor of the supported decision-making model, wherein the person with disability retains the authority to realize legal acts on his own behalf, albeit with the aid and assistance of decision-making supports.[13] This shift aims both to promote the autonomy and the decision-making abilities of persons with disabilities and also to avoid egregious human rights violations that may result from legal capacity restrictions.[14] By contrast, substitute decision-making processes reflect a view of capacity "as selectively present" in some individuals, constructing a "constructed concept" of legal capacity based on "cognitive capabilities," and as a result, they "necessarily privilege[] certain types of people."[15] One leading scholar described the universal view of legal capacity reflected in the CRPD as "the epiphenomenon," because it "enables persons to sculpt their own legal universe—a web of mutual rights and obligations voluntarily entered into with others" and "facilitates uncoerced interactions."[16]

---

[13] Physicist Thomas Kuhn, credited with coining the phrase "paradigm shift," described a new paradigm as "seldom or never just an increment to what is already known. Its assimilation requires the reconstruction of prior theory and the re-evolution of prior fact, an extrinsically revolutionary process that is [never] completed . . . overnight." *See* Kristin Booth Glen, *Changing Paradigms: Mental Capacity, Legal Capacity, Guardianship, and Beyond*, 44 COLUM. HUM. RTS. L. REV. 93, 99 (2012) (quoting THOMAS S. KUHN, THE STRUCTURE OF SCIENTIFIC REVOLUTIONS 7 (3d ed. 1996)) (as quoted in the original).

[14] *See* Lord & Stein (2013), *supra* note 6, at 38 ("Plenary guardianship and other constraints on decision-making, for instance, deprive persons with disabilities of medical decision-making. Some of the most egregious human rights violations against persons with disabilities in this context include forced sterilisation, bogus remedies said to 'cure' disabling conditions, psycho-surgery such as lobotomies and excruciatingly painful medical experimentation") (internal citations omitted); *see also* Rep. of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ¶ 64, U.N. DOC. A/HRC/22/53 (Feb. 1, 2013) (by Juan Méndez) (observing that legal capacity restrictions have historically lent the color of law to acts that may constitute torture).

[15] Amita Dhanda, *Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?*, 34 SYR. J. INT'L. L. & COM. 429, 459-60 (2007).

[16] *See* Gerard Quinn, *Personhood & Legal Capacity Perspectives on the Paradigm Shift of Article 12*, Paper presented at Harvard Law School, Feb. 20, 2010, *reprinted in* NIU Galway Ctr. for Disability Law & Policy, *Submission on Legal Capacity to the Oireachtas Committee on Justice, Defence & Equality* app. 6, at 73, *available at* http://www.nuigalway.ie/cdlp/documents/cdlp_submission_on_legal_capacity_the_oireachtas_committee_on_justice_defence_and_equality_.pdf

Although the CRPD does not describe the precise population that *may* require support in exercising legal capacity, it does apply to persons with disabilities whom many States have traditionally legally restricted from doing so.[17] The *travaux préparatoires* show the extent to which the drafters intended to avoid an interpretation of legal capacity whereby persons with disabilities would be merely recognized as legal persons.[18] Rather, the drafters intended for States to ensure that persons with disabilities act as subjects who may give effect to legal responsibilities and obligations.[19] The final text reflects this intent by requiring decision-making supports that enable persons with disabilities to do so even if on their own they might not functionally appear capable to do so.[20] Unlike most United States guardianship laws, the CRPD does not expressly provide for any circumstances where the decision of a third party may operate as a permissible substitute for the decision of a person with disability.[21] Rather, the CRPD

---

[17] *See* Quinn, *supra* note 16 ("And yes[, Article 12(3)] does apply to even those who – to all outward appearances – cannot form or express a preference or exert their will.").

[18] *See, e.g.*, Letter dated Oct. 7, 2005 from the Chairman to all members of the Committee, 7th sess., Ad Hoc Comm., ¶ 53 (Jan. 16-27, 2006), *in* 2 DISABILITIES AND HUMAN RIGHTS: DOCUMENTS 274 (R. van Laar & C. Tofan eds., 2008), *available at* http://www.un.org/esa/socdev/enable/rights/ahc3reporte.htm ("[G]uardianship or substitute decision-making for persons with disabilities has led to many injustices in the past.").

[19] *See, e.g.*, Background conference document prepared by the Office of the United Nations High Commissioner for Human Rights: Legal Capacity, 6th sess., Ad Hoc Comm., *in* 2 DISABILITIES AND HUMAN RIGHTS: DOCUMENTS, *supra* note 18, at 143-47, ¶¶ 15-25, *available at* http://www.un.org/esa/socdev/enable/rights/documents/ahc6ohchrlegalcap.doc.

[20] *See* CRPD, *supra* note 3, at art. 12(2) (recognizing the right of *all* persons with disabilities to exercise legal capacity); *see also* Dhanda, *supra* note 15, at 461 (describing "the universal reach of the capacity formulation" in Article 12).

[21] *See* Annual Report of the United Nations High Commissioner for Human Rights: Thematic Study on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities, Human Rights Council [hereinafter, "OHCHR Thematic Study"], 10th sess., U.N. DOC. A/HRC/10/48, ¶ 45 (2009) (interpreting Article 12 to prevent legal capacity restrictions whether they are directly or indirectly based on disability); *see also* CRPD Comm., Concluding observations on the initial report of Argentina, Sept. 17-28, 2012, 8th sess., U.N. Doc. CRPD/C/ARG/CO/1, at ¶¶ 19-22 (2012) (one of eight concluding observations interpreting Article 12 to prohibit plenary guardianship); *but see* Dhanda, *supra* note 15, at 460-61 (arguing that Article 12 does not expressly prohibit substitute decision-making, that it contains language that may justify substitute decision-making, but that such an interpretation would fail to consider the negotiations, which support a prohibition).

endorses the universalization of legal capacity by requiring that supported decision-making paradigms replace the existing substitute decision-making arrangements.[22]

B. OUT WITH THE NORMAL, IN WITH THE DIVERSE

In addition to the universal reach of legal capacity, the paradigm shift triggered by the CRPD a more fundamental affirmation of the value of human diversity. Indeed, by "retain[ing] the individual as the primary decision maker[, the CRPD] recognizes that an individual's autonomy can be expressed in multiple ways."[23] That is, autonomy may manifest itself in ways that vary from case to case, including where a person has "individuals in one's life to provide support, guidance and assistance to a greater or lesser degree, so long as it is at the [person]'s choosing."[24] Indeed, the recognition of the diverse manifestation of autonomy in Article 12 of the CRPD complements the "[r]espect for difference and acceptance of persons with disabilities as part of human diversity and humanity" required by Article 3(d),[25] as well as other provisions.[26] The CRPD is unique among international human rights treaties in terms of the value it places on diversity.[27]

---

[22] *See* CRPD, *supra* note 3, at art. 12(3); *see also* OHCHR Thematic Study, *supra* note 21, at ¶ 43.

[23] Robert D. Dinerstein, *Implementing Legal Capacity under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making*, 19 HUM. RTS. BRIEF 8, 10 (2012).

[24] *Id.*

[25] *See* Tina Minkowitz, *The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions*, 34 SYR. J. INT'L L. & COM. 405, 412 (2007); *accord* Bryan Y. Lee, Note, *The U.N. Convention on the Rights of Persons with Disabilities and Its Impact Upon Involuntary Civil Commitment of Individuals with Developmental Disabilities*, 44 COLUM. J.L. & SOC. PROBS. 393, 419-20 (2011) (observing that substitute decision-making arrangements should be considered contrary to the CRPD's premium on diversity).

[26] *See, e.g.*, CRPD, *supra* note 3, at Preamble (m) ("Recognizing the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities, and that the promotion of the full enjoyment by persons with disabilities of their human rights and fundamental freedoms and of full participation by persons with disabilities will result in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty").

[27] *See, e.g.*, Kathleen Cornelsen, Note, *Doubly Protected and Doubly Discriminated: The Paradox of Women with Disabilities After Conflict*, 19 WM. & MARY J. WOMEN & L. 105, 121 (2012) (observing that by contrast the United Nations Convention on the Elimination of Discrimination Against Women does not have similar provisions reaffirming the inherent value of diversity).

In this way, the decision-making paradigm shift enshrined by the CRPD moves beyond previous concepts employed to advance the rights of persons with disabilities.[28] For example, where the purpose of the "normalization" concept was to assist persons with intellectual disabilities to become "well-adjusted members of society" by adapting themselves to the norms and patterns of the mainstream of society to the greatest extent possible,[29] this concept preserved rather than challenged unstated societal norms. Indeed, disability studies scholars have long written about how cultural beliefs about normalcy have impeded persons with disabilities from enjoying equality with others.[30] By contrast, the CRPD presents a challenge to conceive of decision-making capacity, not as an "unstated norm" that some persons with disabilities deviate from,[31] but as a "legal fiction" which merely "tell[s] us when a state legitimately may intrude into an individual's affairs and take action to limit an individual's rights to make decisions about his or her own person or property."[32] That is, by recognizing that all persons with disabilities have legal capacity and by requiring States Parties to find ways to facilitate them to exercise it, the paradigm shift hinges on the insight that constructions of decision-making capacity are "determined by prevailing values, knowledge, and even the economic and political spirit of the time" and that "the criteria or elements needed to establish legal incapacity are the products of

---

[28] *See* Glen, *supra* note 13, at 128-31 (distinguishing the decision-making paradigm shift from the "integration mandate" under the Americans with Disabilities Act, 1990 (amended, 2008), the concept of normalization, and person-centered planning as espoused by regulations of the Centers for Medicare and Medicaid Services).

[29] *Id*. at 129.

[30] *See, e.g.*, Lennard J. Davis, *Constructing Normalcy: The Bell Curve, The Novel, and the invention of the Disabled Body in the Nineteenth Century, in* DISABILITY STUDIES READER 3, 15 (Lennard J. Davis ed., 2d ed., 2006) (articulating a need "to reverse the hegemony of the normal and to institute alternative ways of thinking about the abnormal); PAUL K. LONGMORE & LAURI UMANSKY, INTRODUCTION IN THE NEW DISABILITY HISTORY 36 (Paul K. Longmore & Lauri Umansky eds., 2001) ("The ascendance of normality signaled a shift in the locus of faith from a God-centered to a human-centered world, from a culture that looked within to a core and backward to lost Edenic origins toward one that looked outward to behavior and forward to a perfected future.").

[31] *See* MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION AND THE AMERICAN LAW 51(1990) (observing that "we generally adopt an unstated point of reference when assessing disabled persons and that the point of reference typically expresses perspectives of the majority of power-holders within society").

[32] Charles P. Sabatino & Erica Wood, *The Conceptualization of Capacity of Older Persons in Western Law, in* BEYOND ELDER LAW: NEW DIRECTIONS IN LAW AND AGING 35, 36 (Israel Doron & Ann Snoden eds., 2012).

society's prevailing beliefs concerning individual autonomy and social order, tempered by the restraint of legal precedent."[33] By the same token, this present shift coincides with the latest evolution of societal values and needs, informed in part by a heightened awareness of how legal capacity restrictions lead to egregious human rights violations.[34]

C. AWAY FROM THE (DYS)FUNCTIONAL APPROACH

Finally, the CRPD's decision-making paradigm shift implies a shift away from the "functional approach" to capacity. The "functional approach" describes the view that "capacity [i]s inherently cognitive" and that "incapacity [i]s the inability both to understand information relevant to making a decision and to understand the potential consequences of making—or not making—that decision."[35] The functional approach essentially endorses the imposition of plenary or limited guardianship on "wards" or "incapacitated persons," and is the view prevalent in the United States today.[36] Underpinning this approach is the societal assumption

> that adults of typical intelligence, psychosocial functioning, and sensory ability are able to engage in all aspects of life — deciding where to live, whom (or whether) to marry, how to spend one's money (or to whom to leave it), for whom to vote — on an autonomous basis, with whatever assistance they choose to seek out and consider in their decision making.[37]

The functional approach has increasingly drawn the criticism of medical professionals skeptical about the certainty of capacity assessments.[38] While a medical opinion is currently the accepted standard for determining capacity, "there does not exist a gold standard," since even

---

[33] *Id.*
[34] *See id.*; *see also* Peter Margulies, *Access, Connection, and Voice: A Contextual Approach to Representing Senior Citizens of Questionable Capacity*, 62 FORDHAM L. REV. 1073, 1083 (1994) (describing changes in constructions of decision-making capacity in terms of "a shifting network of values and circumstances").
[35] Glen, *supra* note 13, at 94.
[36] *See id.*
[37] Dinerstein, *supra* note 23, at 9.
[38] *See, e.g.*, Jennifer Moye, *Guardianship and Conservatorship, in* EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS 309, 317-18 (Thomas Grisso ed., 2d ed., 2003) (criticizing traditionally medical assessments of capacity because they commonly rely on different tests).

clinical methods of assessing capacity are flawed.[39] The flaws inherent to capacity assessments are in turn compounded by other factors that undermine the validity of courts' determinations of capacity, including: self-fulfilling stereotypes that persons involved in capacity determinations would not be so involved if they did not truly have diminished capacity, courts' tendency to conflate the reasonableness of a specific decision and a person's capacity to make rational decisions, and courts' tendency to infer that the perceived incapacity to make one decision indicates a global incapacity to make any decisions at all.[40] By contrast, the CRPD "creates a true presumption of 'legal capacity' and calls for a 'more nuanced approach' towards determining decision-making status and greater reflection on how to assist an individual within the decision-making process."[41] Indeed, Article 12(3) "reflects the critical insight that even people with the most significant disabilities have legal capacity and are covered by the CRPD."[42] In this way, the central question becomes not whether a person has capacity, but how his exercise of that capacity may be supported.

While there is no singular supported decision-making model, in contrast to "classic neoliberalism tropes in which individual choice serves as a peremptory norm," this model endorses an emphasis on a person with disability's supported capacity.[43] As a result, supported decision-making arrangements preserve the person with disability's legal right to make decisions without interference from an appointed decision-making agent, at the same time that it may permit the person to enter freely into or to terminate at any time a non-obligatory support

---

[39] *See, e.g.*, Jennifer Moye & Daniel C. Mason, *Assessment of Decision-Making Capacity in Older Adults: An Emerging Area of Practice and Research*, 62B J. GERONTOLOGY 1, 9 (2007).
[40] *See* Salzman, *supra* note 10, at 300-01.
[41] *Id.* at 285.
[42] Dinerstein, *supra* note 3, at 9; *see also* CRPD, *supra* note 3, at Preamble (j) ("[r]ecognizing the need to promote and protect the human rights of all persons with disabilities, including those who require more intensive support").
[43] Lord & Stein (2013), *supra* note 6, at 46.

relationship.[44] Should a person with disability choose to delegate decision-making powers to another, nevertheless the person must actively participate in decision-making; moreover, any substitute decision-making arrangements are to be limited in time and scope.[45] Should a person with disability choose to make decisions with supports, then these decisions are generally legally binding.[46] Despite a need to further develop, document, and test specific supported decision-making practices,[47] this model implies an attitudinal change founded in critical reflection of how unstated societal norms create barriers to persons with disabilities in decision-making beyond their cognitive capabilities or functional capacities.

III. THE MODEL RULES' RESPONSE TO PERECEIVED DIMINISHED DECISION-MAKING CAPACITY

While decision-making capacity may be "the black hole of legal ethics,"[48] Rule 1.14 aims to fill the void by instructing lawyers on steps to take "¨[w]hen a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason."[49] In part, Rule 1.14 intends "to permit developmentally-disabled people to make as many decisions as possible, while protecting them from the harmful effects of bad decisions that they do not fully understand."[50]

---

[44] *See, e.g.*, Salzman, *supra* note 10, at 306.
[45] *See id.* at 307.
[46] *See id.*
[47] *See* Nina A. Kohn, Jeremy A. Blumenthal & Amy T. Campbell, *Supported Decision-Making: A Viable Alternative to Guardianship?*, 117 PENN ST. L. REV. 1111, 1136 (2013) (observing that despite "a growing literature addressing how supported decision-making *should* work . . . there is far less literature on how it in fact *does* work") (emphasis original).
[48] Margulies, *supra* note 34, at 1082.
[49] MODEL RULES 1.14(a).
[50] *In re M.R.*, 638 A.2d 1274, 1281 (N.J. 1994) (New Jersey's Rule 1.14 was the same as the original Model Rule 1.14).

Even if Rule 1.14 may be "one of the most well-intended and progressive of the Model Rules," it has nonetheless received "resounding criticism" for its vagueness.[51]

A. YOU KNOW IT WHEN YOU REASONABLY BELIEVE IT

The Rule 1.14 enshrines an archetypal form of the "functional approach" to capacity. Although it may be advisable for lawyers who have clients with "questionable capacity" to seek guidance from other more experienced attorneys, medical professionals, or support networks and organizations,[52] lawyers do not have a general ethical obligation to educate themselves about the symptoms of intellectual or psycho-social disabilities.[53] Rather, Rule 1.14 entrusts the function of identifying when "questionable capacity" becomes "diminished capacity" to the discernment of the untrained lawyer. Whether a client's capacity is diminished per Rule 1.14(b) is to be determined by the lawyer's reasonable belief of that three conjunctive conditions are met:

> [a] that the client has diminished capacity,
> [b] is at risk of substantial physical, financial or other harm unless action is taken and
> [c] cannot adequately act in the client's own interest.[54]

Notwithstanding periodic revisions, ultimately the criteria contained in Rule 1.14(b) "to define impaired capacity have come up well short of adequate."[55]

---

[51] *See generally* Elizabeth Laffitte, Note, *Model Rule 1.14: The Well-Intended Rule Still Leaves Some Questions Unanswered*, 17 GEO. J. L. ETHICS 313-21 (2004) (tracing the legislative history of Rule 1.14).

[52] *See* Henry Dlugacz & Christopher Wimmer, *The Ethics of Representing Clients with Limited Competency in Guardianship Proceedings*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 331, 366 (2011); *see also id.* (quoting *In re Mental Health of K.G.F.*, 29 P.3d 485, 498 (Mont. 2001)) (adding that attorneys should understand the "range of alternative, less-restrictive treatment and care options available" in the client's community) (internal quotations omitted).

[53] *But see* ABA Comm'n on L. & Aging & Amer. Psych. Ass'n, Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers 8 (2005) [hereinafter, "Diminished Capacity Handbook"] (recommending that lawyers active in in criminal defense, poverty law, probate, and, of course, guardianship practices undertake to educate themselves).

[54] *Compare* MODEL RULES 1.14(b) *with* Daniel L. Bray & Michael D. Ensley, *Dealing with the Mentally Incapacitated Client: The Ethical Issues Facing the Attorney*, 33 FAM. L. Q. 329, 336 (1999) ("The health profession relies on 'decisional capacity' which consists of three elements: (1) possession of a set of values and goals; (2) the ability to communicate and to understand information; and (3) the ability to reason and to deliberate about one's choices.").

Although some scholars praise Rule 1.14 for "recognizing that capacity is an elusive, changing quality and that many clients may have some level of comprehension that should be honored by legal counsel,"[56] even a facial analysis of these criteria reveals there remains much to be desired.[57] First, these criteria provide uncertain guidance for determining whether a client's capacity triggers the Rule's provisions. The definition of "diminished capacity" is circular: that the client has diminished capacity is one of the three conjunctive conditions for determining whether the client has diminished capacity. Moreover, while Rule 1.14 specifies that the potential harm due to the client's diminished capacity must be "substantial," it does not specify what the nature of the precipitating risk.[58] The vagueness of what constitutes requisite imminence or likelihood of the risk is compounded by the Rule's failure to specify by whom action would be necessary to avoid that risk.[59] Also, "adequately" appears to be an impossibly subjective determination. Finally, even judicial determinations of what is a person with intellectual disability's best interests have been criticized for permitting too wide discretion.[60]

B. SITUATION NORMAL, ALL MODELED UP

---

[55] *See* Bray & Ensley, *supra* note 54, at 332; *see also* Laffitte, *supra* note 51, at 322-24 (discussing state-level modifications to Rule 1.14 to provide clearer criteria).

[56] Edward Spurgeon & Mary Jane Ciccarello, *Lawyers Acting as Guardians: Policy and Ethical Considerations*, 31 STETSON L. REV. 791, 822 (2002).

[57] *See* Bray & Ensley, *supra* note 54, at 333-34 ("To make an adequate determination of what the lawyer's responsibility to the impaired client may be, it is necessary to first determine whether the client is 'impaired.' [However, b]ecause there are no set guidelines, lawyers are left to their own faculties to determine a method of determining when a client is impaired which they feel works the best.").

[58] *Cf. Shtukaturov v. Russia*, App. No. 44009/05, Eur. Ct. H.R. 94 (2008) (requiring that "in order to justify full incapacitation the mental disorder must be of a kind or degree warranting such a measure") (internal quotations and citation omitted).

[59] That is, is a risk that might be averted by the client's own action sufficient to consider the client to have diminished capacity or must the risk such that only an attorney's action could avert it?

[60] *See, e.g.*, *E. v. Eve*, [1986] 2 S.C.R. 388, 422-24 (Can.) (reviewing U.S. jurisprudence and rejecting the "best interests" test as a sufficiently workable tool for determining whether to authorize the sterilization of a woman with intellectual disability). In addition, "courts and commentators have often and overwhelmingly rejected the idea that a lawyer should act in what the lawyer determines is the client's 'best interests."' Bray & Ensley, *supra* note 54, at 340.

Once a lawyer has determined that his or her client has diminished capacity, "the lawyer shall, as far as reasonably possible, maintain a *normal* client-lawyer relationship with the client."[61] However, beyond requiring "that a lawyer maintain a traditional attorney–client relationship with such clients, the rule fails to provide much guidance to lawyers in carrying out this endeavor."[62] The difficulty of maintaining attorney–client normalcy is complicated by the reality that clients do not interact with attorneys in the same way they interact with others.[63] On the other hand, a client who is generally "not used to exercising autonomy without interference" may be reluctant to act as an autonomous decision-maker in his or her interactions with an attorney.[64] Even where the client does act as an autonomous decision-maker, the attorney may receive pressure from a judge or other officials to act as the decision-maker in order to expedite favorable results, based on their perception that the client has diminished capacity and their own views about how the attorney should exercise discretion under the Model Rules.[65]

Although a client's diminished capacity does not, in turn, "diminish the lawyer's obligation to treat the client with attention and respect,"[66] the lawyer's obligations differ greatly from those characterizing "a normal client-lawyer relationship." If the lawyer reasonably believes a client to have diminished capacity, he or she may take "reasonably necessary

---

[61] *Id.* (emphasis added).
[62] David A. Green, *"I'm OK—You're OK": Educating Lawyers to "Maintain a Normal Client—Lawyer Relationship" with a Client with a Mental Disability*, 28 J. LEGAL PROF. 65, 68 (2004).
[63] *See* Dlugacz & Wimmer, *supra* note 52, at 346-47 (observing that a client may be "so overwhelmed by the prospect of a negative outcome to the representation that she automatically defers to the attorney, or actively requests that he make all decisions for her, in the belief that doing so will best protect her").
[64] *Id.* at 346.
[65] *See id.*; *see also* Robert B. Fleming & Rebecca C. Morgan, *Lawyers' Ethical Dilemmas: A "Normal" Relationship When Representing Demented Clients and Their Families*, 35 GA. L. REV. 735, 735-36 (2001) ("Many times the other participants in the system respond by treating the incapacitated person in a paternalistic manner rather than the adversarial one upon which the system is designed.").
[66] MODEL RULES 1.14, Cmt. 2.

protective action."[67] Such action falls into two broad categories: less intrusively, the lawyer may "consult[] with individuals or entities that have the ability to take action to protect the client"; or more intrusively, the lawyer may, but only in "in appropriate cases," "seek[] the appointment of a guardian ad litem, conservator or guardian."[68] That is, reasonably necessary protective action may range from placing a phone call with a family member to initiating proceedings that would result in the client's "civil death."[69] Because the Rule does not offer any words of caution against resorting to particularly intrusive measures within the spectrum of possibility,[70] what a lawyer believes to be "reasonably necessary" will vary widely on the lawyer's attitudes about persons with disabilities. While capacity may be "the black hole of legal ethics" because of the degree of discretion involved, overly intrusive protective actions can easily swallow up a client's decision-making autonomy.[71]

Model Rule 1.14 challenges lawyers to maintain "normalcy" in their relationships with clients with intellectual disabilities. "Before a lawyer can understand the directions of Model Rule 1.14, it is necessary to determine what the normal lawyer-client relationship is and what effect the other ethics rules may have on its scope."[72] Also, "[a] normal client-lawyer relationship presumes that there can be effective communication between client and lawyer, and that the client, after consultation, can make considered decisions about the objectives of the

---

[67] *Id.*
[68] *Id.*
[69] *See* Anna Lawson, *The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?*, 34 SYR. J. INT'L. L. & COM. 563, 569 (2007) (describing plenary legal capacity restrictions); *see also* Dhanda, *supra* note 20, at 445 n.77.
[70] *But see* Dlugacz & Wimmer, *supra* note 52, at 340-43 (arguing that whenever an attorney believes a client has diminished capacity, he or she should adopt only the least restrictive means possible); *see, e.g.*, *Practical Approaches to Adult Guardianship*, *in* ALTERNATIVES TO GUARDIANSHIP 15 (Md. Inst. for Continuing Prof'l Educ. of Lawyers, Inc., 2010) (underlining that Maryland law permits guardianship only where "no less restrictive form of intervention is available").
[71] Margulies, *supra* note 34, at 1082.
[72] Bray & Ensley, *supra* note 54, at 338.

representation and the means of achieving those objectives."[73] Where a client does not appear capable of making decisions in his or her best interest, the lawyer may be torn between what he or she thinks is best for the clients versus what the client wants. Thus, determining normalcy becomes subjective and "the Rule and the Comments accompanying Rule 1.14 give little guidance on *how* [a normal relationship] is to be accomplished."[74]

C. EVERY MAN IS AN ISLAND?

Underlying the standard of normalcy recommended by Rule 1.14 is "the assumption that the client, when properly advised and assisted, is capable of making decisions about important matters."[75] Because "a client with diminished capacity often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being" they may well "be quite capable of handling routine financial matters while needing special legal protection concerning major transactions."[76] Comment 1 belies the philosophical underpinning of the United States legal system, which "assumes competent parties with adept legal representation, presenting their respective sides of the case with little involvement by the judge."[77] The justification for restrictions on the legal capacity of a client who is perceived not to conform to this underlying assumption "connects back to the pre-eminence of the rational agent and the undervaluing of the role that social relations play in decision-making and indeed the construction of autonomous selves."[78]

Often clients believed to have diminished capacity also have formal decision-making restrictions; for this reason, Comment 1 to Rule 1.14 clarifies that lawyers are obligated to

---

[73] ABA Comm. on Ethics & Prof'l Responsibility, Formal Op. 96-404 (1996).
[74] *See* Bray & Ensley, *supra* note 54, at 338.
[75] MODEL RULES 1.14, Cmt. 1.
[76] *Id.*
[77] Fleming & Morgan, *supra* note 65, at 735 (adding, however indelicately, "This ideal can be difficult, even impossible, to reach when one party is demented.").
[78] Lord & Stein (2013), *supra* note 6, at 36.

represent their clients first and foremost, not their legal representatives.[79] However, in striking a balance between a lawyer's ethical obligations to uphold confidentiality and to maintain loyalty,[80] Rule 1.14 refers to the client's individual capacity in isolation. In so doing, Rule 1.14 undermines the reality that all persons rely on informal or formal supports in making decisions regardless of their individual, functional capacity.[81] On a basic level, this isolationist view of individual capacity fails to consider that "the development of the human person is an evolving process bound up with the social construction of the self," that is, "it is intrinsically relational."[82] Although "every one of us depends upon and supports each other for decision-making," and "[a]s society becomes more complex, interconnected, and with more choices and stimuli, we will increasingly need more proxies to navigate our existence and make decisions."[83]

Since "[c]lients with mental disabilities may rely to varying degrees on the assistance of family and friends in their everyday lives," naturally they "may want or expect them to be involved in her legal representation, as well."[84] Even so, the values embedded in Rule 1.14 turn managing natural decision-making supports into "thorny ethical problems," specifically because the Rule errs on the side of excluding rather than including such informal supports.[85] As it is, "[r]epresentation of persons with mental disabilities is routinely not of the highest caliber."[86] Undoubtedly, lawyers' lack of experience with disability and time and expense limitations

---

[79] *See* MODEL RULES 1.14, Cmt. 1.
[80] *See id.* at Rule 1.6 and 1.7
[81] *See* Lord & Stein (2013), *supra* note 6, at 45.
[82] *Id.*
[83] *Id.*
[84] *See* Dlugacz & Wimmer, *supra* note 52, at 358.
[85] *See id.*
[86] *Id.* at 365; *see also id.* at 366 ("Since most attorneys do not have experience dealing with clients with mental disabilities and are not trained as mental health professionals, they are often ill-equipped to accurately identify or develop responses to a client's disability. Reading a few articles on mental disability and ethics will not prepare the attorney to deal with the complexities of a client manifesting symptoms of a disability.").

contribute to poor representation.[87] Yet in face of the necessity to spot and head off possible conflicts of interest between clients and their supporters, Comment 3 to Rule 1.14 works to discourages lawyers from recourse to persons who act as legitimate decision-making supports.[88] Comment 3 provides:

> When necessary to assist in the representation, the presence of such persons generally does not affect the applicability of the attorney-client evidentiary privilege. Nevertheless, the lawyer must keep the client's interests foremost and, except for protective action authorized under paragraph (b), must to [*sic*] look to the client, and not family members, to make decisions on the client's behalf.[89]

At the same time that the revised Comment 3 may push back against the perception of some lawyers who had "understood the [prior version of the] Comment to endorse the idea that the lawyer may use their judgment to act in the best interests of the client," it appears to discourage recourse to persons who act as decision-making supports.[90] That is, notwithstanding the appropriate reminder that the client's interests must be kept foremost and that the client is the ultimate decision-maker, because the Comment fails to offer constructive ways in which to engage such supports, not only does the Comment fail to recognize the social construction of self, it also fails to provide useful guidance where, for example, the lawyer has difficulty maintaining effective communication directly with the client. For example, a client perceived to have diminished capacity may be able to effectively communicate with his attorney during a meeting but may require periodic reminders in order to remain capable of making an "informed decision."[91] Although neither the commentary nor the rule provides much guidance as to what

---

[87] *See id.* at 365.
[88] *See id.* at 358 (noting that especially in guardianship proceedings initiated by family members, "it is critical to track where direction is coming from and ensure that the family is assisting the client in making decisions, not making decisions for her").
[89] MODEL RULES 1.14, Cmt. 3.
[90] Bray & Ensley, *supra* note 54, at 340.
[91] *See* MODEL RULES 1.4, Cmts. 1-4.

lawyers must do to ensure "reasonable communication," decision-making supports including family members may be perfectly positioned to fill this gap.[92]

IV. RECOMMENDED MODIFICATIONS TO THE MODEL RULES

Rule 1.14 provides insufficient guidance to non-expert lawyers to assess a client's decision-making capacity, entrenches outmoded notions of "normal" decision-making, and fails to encourage lawyers to consider the decision-making capacity of persons with disabilities together with their legitimate formal or informal supports. Even though the CRPD's obligations are not legally binding on the United States, the decision-making paradigm shift has prompted proponents of the autonomy of persons with disabilities to reassess the adequacy of the Model Rules. While modifying the Model Rules is not sufficient to promote supported decision-making practices in the United States, it represents a measure that will facilitate respect for the autonomy of persons with disabilities among the legal community pending the emergence of these practices. For this reason, this paper proposes that the Model Rules be modified to instruct lawyers to assess clients' supported rather than individual capacity, to require lawyers to consult decision-making supports before taking protective actions, and to encourage lawyers to avail themselves of decision-making supports to strike a balance in fulfilling their other ethical obligations.

A. RULE 1.14(A) SHOULD INSTRUCT LAWYERS TO ASSESS A CLIENT'S SUPPORTED, RATHER THAN INDIVIDUAL CAPACITY

Rather than assess only a client's decision-making capacity as an individual in isolation from the supports he may usually rely on, lawyers should consider it more holistically by taking

[92] *See* Dlugacz & Wimmer, *supra* note 52, at 347.

into consideration how the client usually makes decisions. In order to promote this more holistic perspective, a revised version of Rule 1.14(a) might read thus:

> (a) When a client's capacity to make [~~adequately considered~~] decisions in connection with a representation is diminished, **when assessed in relation to the client's formal or informal decision-making supports,** whether because of minority, mental impairment or for some other reason, the lawyer shall[~~, as far as reasonably possible,~~] maintain a [~~normal~~] client-lawyer relationship with the client **consistent with and respectful of the client's usual decision-making processes**.

In this way, lawyers would be advised not to mistake decision-making capacity for an intelligence quotient or communication skills, but to assess it together with the recognition that in today's increasingly interconnected society fewer people make important decisions – including decisions with legal consequences – without consulting with natural supports.

B. RULE 1.14(B) SHOULD REQUIRE RECOURSE TO INFORMAL DECISION-MAKING SUPPORTS BEFORE TAKING A PROTECTIVE ACTIONS

Although Rule 1.14(b) was amended to raise the threshold for taking protective action,[93] without express guidance to consider the possible harm that may result from inaction as well as the client's ability to act in his own interest in light of his decision-making supports, a lawyer may adopt measures more restrictive of the client's decision-making capacity than are actually necessary. To avoid this eventuality, a revised version of Rule 1.14(b) might read thus:

> (b) When the lawyer reasonably believes that the client [~~has diminished capacity,~~] is at risk of substantial physical, financial or other harm unless action is taken **by him or a decision-making support** and cannot adequately act in the client's own interest **even with decision-making supports**, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

According to this standard, it would become clearer that the lawyer should only consider harms that may result from the failure of either the client or a decision-making support to take action,

---

[93] *See* Laffitte, *supra* note 51, at TBD.

for the client may normally rely on a support in order to avoid such harms. This modification would discourage the lawyer from considering the individual client in isolation when in general he may avoid harms by way of the action of supports as well. In addition, the client's inability to act in his own interest should be established together with the inability of decision-making supports to do so, which would more accurately reflect a situation prompting unilateral protective action by the lawyer.

C. COMMENT 3 SHOULD ENCOURAGE LAWYERS TO RECOGNIZE AND AVAIL OF LEGITIMATE DECISION-MAKING SUPPORTS

Finally, while Comment 3 aims to protect clients' interests in confidentiality and their attorney's loyalty to them, it may discourage lawyers to involve legitimate decision-making supports in important consultations with the client. For example, the present language makes it appear that third parties should participate only when "necessary." Rather, in order to ensure that lawyers avail of clients' decision-making supports even where they may be, for example, facilitative instead of necessary, a revised version of Comment 3 might read thus:

> [3] The client may wish to have family members or other persons participate in discussions with the lawyer. When **they are legitimate decision-making supports and with the client's consent** [~~necessary to assist in the representation~~], the presence of such persons generally does not affect the applicability of the attorney-client evidentiary privilege. Nevertheless, the lawyer must keep the client's interests foremost and, except **for pre-existing supported decision-making arrangements or** for protective action authorized under paragraph (b), must look to the client, and not family members, to make decisions on the client's behalf.

These revisions expressly acknowledge the vital role that decision-making supports play in the lives of persons with disabilities. Moreover, it encourages the lawyer not to harbor prejudices against the involvement of third parties where they have an established relationship with the client as a decision-making support. As decision-making supports become more common, these

revisions will help to introduce lawyers to the existence of such arrangements and to avoid confusion between the roles of supports and those of formal legal representatives.

V. CONCLUSION

Many scholars have described legal capacity deprivations as "civil death."[94] With this in mind, John Donne's prose poem, if read *mutatis mutandis*, suggests how the deleterious effects of such deprivations on some may in turn have ripple effects that reach society at large:

> No man is an island, entire of itself; every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend's or of thine own were: any man's death diminishes me, because I am involved in mankind, and therefore never send to know for whom the bells tolls; it tolls for thee.[95]

That is, if legal capacity deprivations do result in civil deaths for persons with disabilities, then such deaths should ultimately be considered to diminish the lives of all. Indeed, writing in regard to older adults, one scholar has urged that in the aging population demands increased attention to issues of capacity by general practitioners.[96] So, too, with persons with disabilities living increasingly independent lives in the community, will general practitioners encounter capacity issues with increasing frequency.[97] As the practice of supported decision-making (or at least the call for such practices) increases, so will the need to amend Model Rule 1.14 to guide lawyers on engaging with formal and informal decision-making supports.

---

[94] *See, e.g.*, Lawson, *supra* note 69, at 569.
[95] JOHN DONNE, "Meditation XVII," *in* DONNE'S DEVOTIONS 98 (Cambridge U.P., 1923) (language updated from the original).
[96] *See* Charles P. Sabatino, *Representing a Client with Diminished Capacity: How Do You Know It And What Do You Do About It?*, 16 J. AM. ACAD. MATRIMONIAL L. 481, 481 (2000).
[97] *See* Robert D. Dinerstein, *Introduction*, *in* A GUIDE TO CONSENT 1 (Robert D. Dinerstein, Stanley S. Herr & Joan L. O'Sullivan eds., 1999) ("Now more than ever before, persons with disabilities are asserting their right to make major and minor decisions.").