Robert D. Reif Fellowship

Reevaluating Diminished Capacity:
Neuroscience, Disability, and the Limits of Model Rule 1.14

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1. Introduction

There are an estimated one billion people with disabilities worldwide.[1] A person with an intellectual disability, or intellectual developmental disorder, is characterized by deficits in mental abilities, like reasoning, problem solving, planning, and judgment.[2] Individuals with intellectual disabilities may also have support needs in adaptive functioning.[3] Lawyers frequently represent clients with intellectual disabilities, which often triggers concerns about diminished capacity under Rule 1.14.[4] Unlike physicians, who are trained to make decisions about capacity, lawyers are not trained in this area.[5] Comment 6 to Rule 1.14 provides practitioners with a number of factors to consider and balance; however, these factors are largely subjective, creating a risk of lawyers unconsciously stereotyping clients.[6]

Standards of legal capacity are set out by state laws for several different tasks, including consenting to treatment and making a will or contract.[7] Cornell Law School defines capacity as the ability to make a rational decision based upon all relevant facts and considerations.[8] In

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[1] United Nations Human Rights Treaty Bodies, *Committee on the Rights of Persons with Disabilities* (2026), https://www.ohchr.org/en/treaty-bodies/crpd.

[2] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 31 (5th ed. 2022).

[3] James Sheerin, Fionnuala Larkin & Samantha Dockray, *Perceptions of People with Intellectual Disabilities on Autonomy and Decision-Making in Daily Life: A Systematic Review and Synthesis of Qualitative Studies*, 70 J. Intell. Disability Rsch. 225, 226 (2025).

[4] Model Rules of Pro. Conduct r. 1.14 (A.B.A. 2024).

[5] Rachel Harp, *The Dangers of Model Rule 1.14*, U. Cincinnati L. Rev. (2021), https://uclawreview.org/2021/08/11/the-dangers-of-aba-model-rule-1-14/.

[6] Model Rule 1.14, *supra* note 4 at Comment 6; *See* Harp, *supra* note 5.

[7] Charlie Sabatino & Erica Wood, *Fundamental Principles to Guide Capacity Assessment: The Ten Commandments of Mental "Capacity" and the Law*, A.B.A. Comm. On Law and Aging (Sept.-Oct. 2018), https://www.americanbar.org/groups/law_aging/publications/bifocal/vol-40/issue-1-september-october-2018/10-commandments/.

[8] Cornell Law School, *Capacity*, Wex Toolbox (2022), https://www.law.cornell.edu/wex/capacity.

disability law, "capacity" is an evolving term, defined as the ability to perform a task or make a decision.[9] However, changes at the international level have raised questions about "capacity" as a legal term.[10] In 2006, the U.N. Committee on the Rights of Persons with Disabilities set forth legal and policy directives regarding the rights of persons with disabilities.[11] The Convention on the Rights of Persons with Disabilities (CRPD) was adopted by the UN General Assembly in 2006 and entered into force in 2008.[12] The United States is one of six countries in the world who chose not to ratify the CRPD, although the country did sign the CRPD in 2009.[13] While the U.S. has claimed that it already complies with the objectives of the CRPD, primarily through the 1990 Americans with Disabilities Act, the country falls below the CRPD's standards for the right to legal capacity for people with disabilities.[14]

While differences in emotional and social cognition are often interpreted by lawyers as loss of comprehension or reasoning capacity, neuroscience research suggests that reasoning ability and decision-making processes are more complex and variable than traditional legal standards assume.[15] When viewed through the lens of modern neuroscience, Rule 1.14 is flawed

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[9] Sabatino & Wood, *supra* note 7.

[10] *Id.*

[11] Elizabeth Schroeder, *No Need for the CRPD?: Disability, Reproductive Autonomy, and Legal Capacity in the United States*, Geo. Wash. Int'l. L. & Pol'y.Brief (Oct. 24, 2022), https://studentbriefs.law.gwu.edu/ilpb/2022/10/24/no-need-for-the-cprd-disability-reproductive-autonomy-and-legal-capacity-in-the-united-states/.

[12] Hanfried Helmchen, Norman Sartorius & Jakov Gather, Ethics in Psychiatry European Contributions 38, ch. 3 Matthe Scholten, *Mental Capacity and Supported Decision-Making* (2nd ed. 2025). https://link.springer.com/chapter/10.1007/978-94-024-2274-0_3.

[13] Schroeder, *supra* note 11.

[14] *Id.*

[15] *See* Tom Macpherson et al., *Editorial: Circuit, Molecular, and Developmental Mechanisms in Decision-Making Behavior*, 17 Front. Neurosci. 1 (2023) (discussing the recent findings from multi-disciplinary and multi-species

because it encourages lawyers to mistake communicative and behavioral differences for decisional incapacity. A working group led by Hon. Patrick L. Woodward, Chief Judge of the Appellate Court of Maryland (Ret.) recently advocated that the model rule should be updated "to be consistent with the most recent science and literature around capacities and decisional supports and accommodations."[16] Other scholars have already proposed a framework for representing clients subject to guardianship through Rule 1.14 and have advocated for changes to Comments 2 and 4 that accompany the rule.[17]

This paper argues that the factors listed in Comment 6 are subjective and flawed, because they rely on behavioral indicators that neuroscience demonstrates are unreliable measures of decision-making capacity. Section 2 provides necessary background information regarding Model Rule 1.14, the history of misinterpreting capacity, and the neuroscience of decision-making. Section 3 discusses the practical challenges of applying Comment 6 and the ethical and legal consequences of misinterpreting capacity under Rule 1.14. Section 4 advocates for several proposed changes that are supported by neuroscience. If adopted, these proposals would increase autonomy for persons with disabilities, while maintaining protective safeguards that are necessary in some cases. Finally, Section 5 addresses other important considerations and alternative approaches to the problems presented by Rule 1.14.

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studies focused on how technological and methodological advancements have illuminated the neural mechanisms underlying decision-making).

[16] Charles P. Sabatino, *Maryland's Major Rethinking of Model Rule 1.14*, A.B.A. Comm. On Law and Aging (July 2023), https://www.americanbar.org/groups/law_aging/publications/bifocal/vol44/bif-vol44-issue6/model-rule-rethinking/.

[17] *See* Nina A. Kohn & Catheryn Koss, *Lawyers for Legal Ghosts: the Legality and Ethics of Representing Persons Subject to Guardianship*, 91 Wash. L. Rev. 581, 633-35 (June 2016) (proposing that "both Comment 2 and Comment 4 be replaced in favor of a unified comment that explicitly addresses representation of persons subject to guardianship") https://digitalcommons.law.uw.edu/wlr/vol91/iss2/16/.

2. Background: Defining Decision-Making Capacity

As a legal and ethical matter, the capacity of all adults is and should be presumed.[18] Capacity is specific to the task at hand; the lawyer must examine capacity by focusing on the very function being questioned, rather than ability to perform other acts.[19] When a client's capacities are questioned, the party challenging capacity has the burden to produce evidence that establishes diminished capacity.[20] The role of the attorney is to advocate for their client's expressed preferences, rather than to impose the attorney's own preferences on the client.[21] This section addresses background information regarding 1) Rule 1.14 of the Model Rules, 2) the history of misinterpreting capacity in people with disabilities, and 3) the complexity of decision-making as demonstrated by neuroscience research.

2.1 Rule 1.14 and Clients with Diminished Capacity

Most court systems in the U.S. have adopted the American Bar Association's Model Rules of Professional Conduct.[22] This paper focuses primarily on Model Rule 1.14, which addresses the representation of clients with diminished capacity.[23] The rule directs lawyers to maintain a normal client-lawyer relationship with clients that have diminished capacity, and allows the lawyer to take protective action when 1) the lawyer *reasonably believes* that the client has diminished capacity; 2) the client is at risk of harm unless action is taken; and 3) the client

[18] Sabatino & Wood, *supra* note 7 at 483, 489-90.

[19] *Id.*

[20] *Id.*

[21] Kohn & Koss, *supra* note 17 at 614.

[22] *Id.* at 615; Model Rules of Pro. Conduct (A.B.A. 2024).

[23] Model Rule 1.14, *supra* note 4.

cannot adequately act in their own interest.[24] Rule 1.0 (i) states that "reasonably believes" means that "the lawyer believes the matter in question and that the circumstances are such that the belief is reasonable."[25] Lawyers are frequently required to assess the capacity of their clients, and Comment 6 to Rule 1.14 suggests that lawyers should consider and balance several factors in determining the extent of a client's diminished capacity.[26] These balancing factors can muddy the waters rather than clearing them.

While it is not the main focus of this paper, it is important to note that Model Rule 1.14 also protects information relating to the representation of clients with diminished capacity under Rule 1.6, which has specific requirements regarding confidentiality of information.[27]

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[24] Model Rule 1.14, *supra* note 4 (Model Rule 1.14 (a) states, "When 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, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client." Rule 1.14 (b) states, "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 and cannot adequately act in the client's own interest, 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."

[25] Model Rules of Pro. Conduct r. 1.0 (i) (A.B.A. 2024).

[26] Model Rule 1.14, *supra* note 4 at Comment 6 (stating that, "In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision, variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician."

[27] Model Rule 1.14, *supra* note 4 (Model Rule 1.14 (c) states, "Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests"); Model Rules of Pro. Conduct r. 1.6 (A.B.A. 2024) (explaining the ethical guidelines regarding confidentiality of information).

2.2 The History of Misinterpreting Capacity of People with Disabilities

Historical and current events demonstrate a recurring pattern: legal institutions have consistently misinterpreted cognitive or behavioral differences as evidence of incapacity, while persons with disabilities are persecuted, overridden, and underrepresented. Worldwide, individuals with disabilities have historically been mistreated and persecuted. At the beginning of World War II, Adolph Hitler ordered widespread "mercy killing" of persons with disabilities.[28] The euthanasia program was instituted to eliminate "life unworthy of life" and systematically killed 75,000 to 250,000 people with disabilities from 1939 to 1941.[29]

Misjudgments about the capacity of people with disabilities have occurred in a variety of contexts throughout U.S. history. In 1907, Indiana became the first of 24 states to enact a eugenic sterilization law for "confirmed idiots, imbeciles and rapists" in state institutions.[30] In 1927, the Supreme Court of the United States held that compulsory sterilization was constitutional in *Buck v. Bell*.[31] In that case, an Act of Virginia stated that the health of the patient and the welfare of society could be promoted in certain cases by sterilizing "mental defectives."[32] The Court upheld a Virginia court's judgment ordering that Carrie Buck, a "feeble-minded" woman committed to a

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[28] *See* Institute on Disabilities, *Disability Rights Timeline*, Temple U. (2019) (describing the timeline of the disability rights movement, beginning in 1907 with the Indiana eugenic sterilization law and continuing to the present day).
[29] *Id.*
[30] *Id.*
[31] *Buck v. Bell*, 274 U.S. 200, 584 (1927).
[32] *Id.*("An Act of Virginia approved March 20, 1924...recites that the health of the patient and the welfare of society may be promoted in certain cases by the sterilization of mental defectives, under careful safeguard, etc.; that the sterilization may be effected in males by vasectomy and in females by salpingectomy, without serious pain or substantial danger to life; that the Commonwealth is supporting in various institutions many defective persons who if now discharged would become a menace but if incapable of procreating might be discharged with safety and become self-supporting with benefit to themselves and to society; and that experience has shown that heredity plays an important part in the transmission of insanity, imbecility, etc.")

state mental institution, be sterilized at the age of eighteen years old, adding that "three generations of imbeciles are enough."[33] This case illustrates the dangers of allowing perceived cognitive impairment to justify overriding individual autonomy.

In 1990, Congress described in the Americans with Disabilities Act that society has historically isolated and segregated individuals with disabilities, and that these forms of discrimination are continuous, serious, and pervasive.[34] Nine years later, the Supreme Court discussed in *Olmstead* that the Americans with Disabilities Act was designed to address historical segregation, isolation, and stigma experienced by individuals with intellectual disabilities.[35] Today, there is greater focus on support and empowerment of persons with intellectual disabilities.[36]

Despite today's focus on support and empowerment, a recent study found that persons with intellectual disabilities continue to feel that decisions are made for them and without their input.[37] The researchers suggested that these individuals with disabilities were not given the opportunity to assert their autonomy and independence.[38] The study highlighted that societal shifts toward inclusivity have not prevented persons with intellectual disabilities from experiencing inequality and underrepresentation.[39] It is also worth noting that disability has only

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[33] *Id.* at 584-85.

[34] *See* Americans with Disabilities Act of 1990, 42 U.S.C. § 12101(a)(2) *et seq.* (1990) (stating that, "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.")

[35] *Olmstead v. I.C. ex rel. Zimring*, 527 U.S. 581, 598-601 (1999); Leslie Salzman, *Using Domestic Law to Move Toward a Recognition of Universal Legal Capacity for Persons with Disabilities*, 39 Cardozo L. Rev. 521, 523 (2017), https://larc.cardozo.yu.edu/cgi/viewcontent.cgi?article=1433&context=faculty-articles.

[36] Sheerin, Larkin & Dockray, *supra* note 3 at 226.

[37] *Id.* at 225.

[38] *Id.* at 237.

[39] *Id.* at 238.

recently become more visible as a relevant identity in discussions about intersectionality, contributing to misunderstandings and misinterpretations regarding their capacity.[40]

2.3 Neuroscience and the Complexity of Decision-Making

As discussed in the previous section, the history of misinterpreting decision-making capacity of persons with disabilities has been largely driven by discrimination and judgments based on external observations. Yet, current research demonstrates that decision-making is a complex and multi-faceted process that is still not completely understood by neuroscientists.[41] In recent years, progress in neuroscience has elucidated the biological processes of working memory, attentional control, and cognitive flexibility, all of which contribute to decision-making.[42] Recent research has moved away from simplistic models of decision-making to models that include multiple distinct and interacting neural systems, better encompassing the complexity of learning and decision-making.[43] Studies have also established that the sub-processes of perception, evaluation, and response preparation overlap in time and regions of the brain, not necessarily happening in a sequential order.[44]

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[40] Mary Wickenden, *Disability and Other Identities? – How Do They Intersect?*, 4 Front. Rehabil. Sci. 1, 2 (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10449449/.

[41] Macpherson et al., *supra* note 15 at 1.

[42] *Id.* at 2.

[43] Anne G.E. Collins & Amital Shenhav, *Advances in Modeling Learning and Decision-Making in Neuroscience*, 47 Neuropsychopharmacology 104, 114 (2022), https://www.nature.com/articles/s41386-021-01126-y.

[44] Mrugsen N. Gopnarayan, Jaan Aru & Sebastian Gluth, *From DDMs to DNNs: Using Process Data and Models of Decision-Making to Improve Human-AI Interactions*, 11(4) Decision 468, 472 (2024), https://arxiv.org/abs/2308.15225.

Modern neuroscience also demonstrates that decision-making is affected by different personality traits, supporting the idea that it varies significantly across individuals.[45] In fact, one recent study found that different personality traits resulted in significant correlations with emotional or cognitive information processing for decision-making.[46] This may suggest that individuals with developmental disabilities who appear more emotional may just have a different decision-making process than those who appear more "cognitive" or rational. Moreover, the same study explained that decision-making has traditionally focused only on the cognitive aspects of decision-making, but that modern neuroscience is taking into account the emotional component of decision-making, especially in uncertain situations.[47] This is especially relevant for the legal system, in which clients are often put in new and uncertain situations.

Neuroscientists use electroencephalograms (EEGs) and autonomic measure recordings to measure physiological responses during an individual's decision-making process.[48] EEG measurements reveal cognitive effort required by the decision-making process, while autonomic measures reveal emotional engagement and stress-levels during the decision-making process.[49] One study found that EEG and autonomic measurements taken during different tasks showed "distinct correlation patterns with different decisional styles, maximization traits, and personality

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[45] Davide Crivelli, Carlotta Acconito & Michela Balconi, *Emotional and Cognitive "Route" in Decision-Making Process: The Relationship between Executive Functins, Psychopsyiological Correlates, Decisional Styles, and Personality*, 1497) Brain Sci. 734, (2024).

[46] *Id.* at 741.

[47] Crivelli et al., *supra* note 45 at 735.

[48] Michela Balconi, Laura Angioletti & Carlotta Acconito, *Self-Awareness of Goals Task (SAGT) and Planning Skills: The Neuroscience of Decision Making*, 13(8) Brain Sci. 1163, 1165 (2023), https://www.mdpi.com/2076-3425/13/8/1163.

[49] *Id.*

traits."[50] This may suggest that different individuals experience varying levels of stress and emotional engagement while performing the same task. In the context of the legal system, where clients are often put under large amounts of stress over long periods of time, it is important to take this recent research into account.

Studies have also revealed variability in decision-making across clinical populations, particularly when weighing the value of different options.[51] The complex circuit, molecular, and developmental mechanisms underlying decision-making will likely be further elucidated by genetic engineering methods, advanced cognitive tasks, and new computational techniques.[52]

Considering research that demonstrates the multi-faceted nature of decision-making, lawyers should be careful when making ultimate decisions regarding the capacity of individuals to make rational decisions. In fact, one recent study found that labelling behaviors as "irrational" without comprehensive measurements is unwarranted.[53] While this paper does not advocate for comprehensive biological measurements of every individual when lawyers evaluate capacity of their clients, this neuroscience research should act as an alert to the legal community that the factors listed in Comment 6 may perpetuate stereotypes against persons with disabilities.

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[50] Crivelli et al., *supra* note 45.

[51] Collins & Shenhav, *supra* note 43 at 113.

[52] Macpherson et al., *supra* note 15 at 2.

[53] Garrett Thoelen & Paul J. Zak, *Neural Diversity and Decisions*, 10 Adaptive Hum. Behav. & Physiology 109, 122, https://link.springer.com/article/10.1007/s40750-024-00237-2.

3. Analysis: The Limits of Rule 1.14's Capacity Framework

While Rule 1.14 allows lawyers to make judgments about client capacity, modern neuroscience and legal history suggest that such judgments by lawyers are prone to error. In particular, the factors in Comment 6 encourage lawyers to rely on behavioral indicators, like inconsistency, emotional variability, and perceived irrationality. Neuroscience discussed in the previous section suggests that these behavioral indicators are unreliable measures of an individual's decision-making ability. This section addresses 1) the practical challenges that lawyers face while applying the current factors in Comment 6, and 2) the consequences of misinterpreting capacity under Rule 1.14.

3.1 The Practical Challenges of Assessing Capacity

Even though the starting presumption is capacity for a typical adult client, lawyers regularly make capacity judgments without formal capacity assessment training.[54] In doing so, Comment 6 instructs them to consider and balance several factors to determine the extent of a client's diminished capacity.[55] These factors include: 1) the client's ability to articulate reasoning leading to a decision; 2) variability of state of mind; 3) ability to appreciate consequences of a decision; 4) the substantive fairness of a decision; and 5) the consistency of a decision with the known long-term commitments and values of the client.[56] These factors are vague and subjective, allowing lawyers to unconsciously play into stereotypes and their own biases when assessing a

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[54] Charles Sabatino, *Representing a Client with Diminished Capacity: How Do You Know It And What Do You Do About It?*, 16 Clients with Diminished Capacity 481, 482, 483, 489-90 (2000), https://www.aaml.org/wp-content/uploads/representing_a_client_with_diminished-16-2.pdf.

[55] Model Rule 1.14, *supra* note 4 at Comment 6.

[56] *Id.*

client's capacity.[57] For example, evaluating the "fairness" of a client's decision requires a lawyer to make a normative judgment about whether the decision seems reasonable. As a result, lawyers can conflate diminished capacity with personal disagreement over a client's decision.

While a factor-test may seem like an objective way of assessing capacity in theory, Comment 6 allows lawyers to subjectively and unilaterally make decisions about client capacity in practice.[58] For example, in *S.T.*, a New Jersey court held that an attorney acted in good faith under the Rules of Professional Conduct when he requested the appointment of a guardian ad litem based on his reasonable belief that his client's cognitive and mental impairments affected her ability to objectively view the strengths and weaknesses of her case.[59] The attorney's reasonable belief was developed from his understanding of his client's medical records and conversations with his client.[60]

However, the clarity provided by medical records in *S.T.* is not provided in all cases. In fact, other recent cases demonstrate the challenges that lawyers face when determining client capacity with Rule 1.14.[61] For example, in *Manby*, the court held that an attorney breached his ethical duties under Rule 1.14 when he failed to discover his client's "obvious" and "significant" mental impairment.[62] However, medical evidence in the case also demonstrated "uncertainty" regarding the client's mental functioning; the client had both cognitive good days and bad days.[63]

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[57] Harp, *supra* note 5.

[58] *See id.*

[59] *S.T. v. 1515 Broad Street*, *L.L.C.,* 227 A.3d 1190, 1201 (N.J. Sup. Ct. 2020).

[60] *Id.*

[61] *See In re Manby*, 308 A.3d 465 (Vt. 2023); *S.T.*, 227 A.3d 1190, *In re Disciplinary Proceeding Eugster*, 209 P.3d 435 (Wash. 2009).

[62] *See In re Manby*, 308 A.3d at 484.

[63] *See id.* at 483.

It is difficult to reconcile "uncertain" medical evidence with the court's finding of "obvious" and "significant" mental impairment. Even when a court finds that it should have been obvious to a lawyer that their client was or was not capable, that is also a subjective opinion.

Additionally, the vague factors listed in Comment 6 give lawyers a great deal of discretion, making the rule ripe for abuse by ill-intentioned attorneys.[64] For example, in *Eugster*, the court held that an attorney violated an ethical duty that caused actual and potential harm to his client and the legal profession when he filed a guardianship petition to have his client declared incompetent "knowingly and with intent."[65] As a result, the attorney was suspended from the practice of law for 18 months and ordered to pay restitution.[66] The court emphasized that a lawyer's decision to have her client declared incompetent is a serious act that should be taken only after an appropriate investigation and careful, thoughtful deliberation.[67]

Taken together, these cases highlight the difficulty and subjectivity of capacity determinations under Rule 1.14. Because Comment 6 directs lawyers to evaluate capacity based on subjective and behavioral factors, it creates a structural risk that lawyers will misinterpret cognitive differences as evidence of diminished capacity. This risk is compounded by neuroscience research suggesting that such behavioral indicators are not reliably linked to decision-making capacity.

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[64] *See Eugster*, 209 P.3d 435 (Wash. 2009).

[65] *Id.* at 452.

[66] *Id.*

[67] *Id.*

3.2 The Ethical and Legal Consequences of Misinterpreting Capacity

When capacity is misinterpreted using Rule 1.14, the most severe ethical and legal consequences are increased paternalism and diminished autonomy. The client as an individual and the client-lawyer relationship can be hurt or damaged even by *raising* the issue of capacity, let alone misinterpreting it.[68] The harms of misinterpreting capacity arise directly from the current framework of Rule 1.14, which equates cognitive and behavioral differences with diminished capacity. Clients are required to make several decisions that primarily implicate their own personal values, wants, and desires.[69] In those types of decisions, the client is the expert, rather than the lawyer.[70] Allowing a client to make significant decisions ensures that the client's preferences are advocated for, especially when the client's choice is contrary to the lawyer's preferences.[71]

Despite this, lawyers often act paternalistically when making capacity determinations. Lawyers act paternalistically when they interfere with the choice of a client, against that client's will, to promote that client's wellbeing or avoid harm to that client.[72] Paternalistic lawyers can mistake a disagreement as a client's "lack of sophistication," even when that client may be entirely rational regarding their decision.[73] Although paternalism often comes from a place of

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[68] Sabatino, *supra* note 54 at 489-90; Christine Bigby & Alan Hough, Disability Practice: Safeguarding Quality Service Delivery 203, ch.11 Christine Bigby, *The Right to Participate in Decision Making: Supported Decision Making in Practice* (2024).

[69] Robert D. Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 Ariz. L. Rev. 501, 516 (1990), https://journals.librarypublishing.arizona.edu/arizlrev/article/id/8371/#!.

[70] *Id.*

[71] Paul R. Tremblay, *On Persuasion and Paternalism: Lawyer Decisionmaking and the Questionably Competent Client*, 1987 Utah L. Rev. 515, 524 (1987).

[72] *See* Helmchen et al., *supra* note 12 at 29.

[73] Dinerstein, *supra* note 69.

wanting to protect a client, it can cause more harm to the client because making one's own decisions is important for psychological and social wellbeing.[74]

Autonomy, or self-determination, is defined as choosing and acting freely, according to one's own life plan.[75] In a country that operates on a commitment to independence and individual autonomy, the right to make decisions about one's own life is important, especially for members of historically marginalized groups.[76] One scholar has gone as far as to say that "respect for autonomy is a cornerstone of liberal legal theory and of the American political system."[77] Another scholar has equated a legal client's autonomy interests in controlling her affairs to a medical patients' interest in maintaining control over her body, which includes avoiding control and manipulation by an individual of greater status.[78]

When a lawyer misinterprets the extent of a client's capacity, the consequences can be significant. A lawyer who determines that a client has diminished capacity may take protective measures deemed necessary, which may include appointing a guardian ad litem, conservator or guardian to protect the client's interest.[79] Although these protective measures by the lawyer may

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[74] Sabatino, *supra* note 54 at 489-90; Christine Bigby & Alan Hough, Disability Practice: Safeguarding Quality Service Delivery 202-03, ch.11 Christine Bigby, *The Right to Participate in Decision Making: Supported Decision Making in Practice* (2024).

[75] Dinerstein, *supra* note 69 at 512 (citing James F. Childress, *Who Should Decide? Paternalism in Health Care*, 48 Perspectives in Bio. & Med. 452 (1985)).

[76] Christine Bigby & Alan Hough, Disability Practice: Safeguarding Quality Service Delivery 202, ch.11 Christine Bigby, *The Right to Participate in Decision Making: Supported Decision Making in Practice* (2024); David Luban, *Paternalism and the Legal Profession*, 1981 Wis. L. Rev. 454, 464 (1981); Dinerstein, *supra* note 66 at 513.

[77] Dinerstein, *supra* note 69 at 513.

[78] Tremblay, *supra* note 71 at 524.

[79] Model Rule 1.14, *supra* note 4 at Comments 5, 7 (Comment 5 states, "If a lawyer reasonably believes that a client is at risk of substantial physical, financial or other harm unless action is taken, and that a normal client-lawyer relationship cannot be maintained as provided in paragraph (a) because the client lacks sufficient capacity to communicate or to make adequately considered decisions in connection with the representation, then paragraph (b)

be well-intentioned, they effectively transfer autonomy and decision-making authority from the client to the lawyer and other individuals. This dynamic raises serious ethical concerns because it risks undermining client autonomy and reproducing historical patterns of discrimination against persons with disabilities.[80] In contrast, clients who feel empowered by their client-lawyer relationship may bring that sense of power into other parts of their lives and communities.[81]

4. Proposed Solutions Supported by Neuroscience

In this section, I propose three solutions that refine Rule 1.14 to better align with scientific understanding of decision-making while preserving the rule's protective function: 1) specific changes to the current Comment 6 factors, 2) an addition to Comment 6 encouraging lawyers to self-reflect on their own biases when evaluating client capacity, and 3) a new Comment that suggests implementation of supported decision-making interventions before assessing client capacity with the Comment 6 factors.

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permits the lawyer to take protective measures deemed necessary. Such measures could include: consulting with family members, using a reconsideration period to permit clarification or improvement of circumstances, using voluntary surrogate decisionmaking tools such as durable powers of attorney or consulting with support groups, professional services adult-protective agencies or other individuals or entities that have the ability to protect the client..."; Comment 7 states, "If a legal representative has not been appointed, the lawyer should consider whether appointment of a guardian ad litem, conservator or guardian is necessary to protect the client's interests...")

[80] Disability Rights Timeline, *supra* note 28.

[81] *See* Dinerstein, *supra* note 69 at 523.

4.1 Changes to Comment 6 Factors

Neuroscience research suggests that decision-making capacity is complex and variable among individuals.[82] Yet, the factors listed in Comment 6 rely on behavioral indicators, such as inconsistency, emotional variability, and perceived irrationality. These vague and subjective factors systematically bias lawyers toward misinterpreting cognitive and behavioral differences as diminished capacity. The following proposed changes are unified by the principle that capacity should be inferred by client understanding, rather than subjective judgments of client behavior.

The first factor for determining extent of capacity in Comment 6 is the client's ability to articulate reasoning leading to a decision.[83] Individuals with intellectual or developmental disabilities may communicate or process information differently while still possessing meaningful understanding and reasoning. Decision-making involves sub-processes of perception, evaluation, and response preparation that overlap in time and regions of the brain.[84] Therefore, the ability to articulate reasoning is an unreliable factor to consider for decision-making capacity. A more evidence-based factor would be *demonstrated understanding in any form*.

The second factor for determining extent of capacity in Comment 6 is the client's variability of state of mind.[85] As mentioned previously, neuroscience research shows that decision-making is significantly affected by personality traits.[86] Particularly for individuals with disabilities that affect their emotional state, variability of state of mind may be a part of their

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[82] *See* discussion *infra* Section 2.3.

[83] Model Rule 1.14, *supra* note 4 at Comment 6.

[84] Gopnarayan, Aru & Gluth, *supra* note 44 at 5.

[85] Model Rule 1.14, *supra* note 4 at Comment 6.

[86] Crivelli et al., *supra* note 45.

normal functioning. For example, certain learning disabilities are often associated with emotional-behavioral problems.[87] This does not mean that individuals with these disabilities cannot think rationally or make their own decisions.[88]

The third factor for determining extent of capacity in Comment 6 is the client's ability to appreciate the consequences of a decision.[89] This is indisputably an important factor that is unaffected by neuroscience research. However, lawyers should recognize that a client could understand the consequences of a decision and still make a choice that certain lawyers may disagree with. In other words, making a risky decision does not mean that someone does not appreciate the consequences.

The fourth factor for determining extent of capacity in Comment 6 is the substantive fairness of a decision.[90] Behavior that appears irrational to a lawyer may in fact reflect differences in personality or decisional style, such as emotional information processing rather than cognitive information processing.[91] Neuroscience research therefore undermines the assumption that there is a substantive "fair" outcome against which decisions can be measured. Evaluating the substantive "fairness" of a decision invites paternalism into the legal system by encouraging lawyers to substitute their own values for the client's. Therefore, this factor should be removed from Comment 6 or heavily limited.

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[87] *See* Paola Critofani et al., *Specific Learning disabilities and Emotional-Behavioral Difficulties: Phenotypes and role of the Cognitive Profile*, 12(5) J.Clin. Med. 1882, 1883 (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10003319/.

[88] *See id.*

[89] Model Rule 1.14, *supra* note 4 at Comment 6.

[90] Model Rule 1.14, *supra* note 4 at Comment 6.

[91] Crivelli et al., *supra* note 45.

The fifth and final factor for determining extent of capacity in Comment 6 is the consistency of a decision with the known long-term commitments and values of the client. Neuroscience research suggests that personality traits may have significant impact on decision-making processes.[92] Personality traits are similar to "long-term commitments and values," so this is likely an important factor that should not be amended. It is possible for a client to rationally or reasonably change their mind about a long-term commitment or long-held value. Therefore, this factor is only relevant when it is tied to someone's lack of understanding; it should not be a determining factor.

4.2 Addition to Comment 6: Medical Decision-Making Capacity as a Guide

Scholars encourage assessors of *medical* decision-making capacity to self-reflect on their own biases.[93] This is because decision-making can be connected to "one's background, culture, lifestyle, or other personal factors."[94] Due to the subjectivity of the Comment 6 factors, this paper proposes an addition to Comment 6 that encourages lawyers to follow the same practice as medical assessors when determining decision-making capacity of their clients: *When balancing the factors, lawyers should consider whether the client's decision reflects a lack of understanding, or merely a difference in values, background, culture, lifestyle, or other personal factors*.

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[92] *Id.*

[93] Eri K. Bailey, Megan Stockamp & Adam Fusick, Inpatient Neuropsychology 342, ch. 13 *Assessment of Decisional Capacity* (2026), https://link.springer.com/chapter/10.1007/978-3-032-05880-5_13.

[94] *Id.*

4.3 New Comment to Rule 1.14: Supported Decision-Making Interventions

When clients make their own decisions, it enhances their individual autonomy and the client-lawyer relationship.[95] Decision-making abilities can be significantly enhanced by simple interventions.[96] In the healthcare context, supported decision-making means providing interventions that enhance a patient's ability to make treatment decisions based on their own values and preferences.[97] This section proposes that the legal system should also adopt supported decision-making; lawyers should prioritize *supporting* a client's ability to make decisions before assessing a client's capacity through the Comment 6 factors.

Even though the U.S. is not a State Party to the CRPD, the convention is a guide for supported decision-making and should serve as a guide for this proposal.[98] Article 12, Section 2 of the CRPD states that, "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."[99] This section therefore encourages a legal system that supports persons with disabilities in making their own decisions. Article 12, Section 3 of the CRPD states 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."[100] This furthers the proposal of providing support to persons with disabilities so

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[95] Dinerstein, *supra* note 69 at 512.

[96] Christine Bigby & Alan Hough, Disability Practice: Safeguarding Quality Service Delivery 202, ch.11 Christine Bigby, *The Right to Participate in Decision Making: Supported Decision Making in Practice* (2024); *See* Helmchen et al., *supra* note 12 at 40.

[97] *See* Helmchen et al., *supra* note 12 at 38.

[98] Convention on the Rights of Persons with Disabilities, May 3, 2008, A/RES/61/106, Annex I.

[99] *Id.* at art. 12, § 2.

[100] *Supra* note 98 at art. 12, § 3.

that they can exercise their legal capacity, rather than "protecting" them after finding that they cannot participate in the legal system due to communication, behavioral, or other ways of being.

Using the CRPD as a guide, a new comment that specifically lists supported decision-making interventions should be added to Rule 1.14. The new comment should list the interventions mentioned by the UN Committee on the Rights of Persons with Disabilities in 2014: 1) assistance by trusted persons; 2) peer support; 3) advocacy; 4) assistance with communication; and 5) advance care planning.[101] Other interventions to consider are allowing additional time for decision-making and consulting professionals to improve communication rather than to replace the client's authority. This new comment would also state that these interventions should be implemented prior to assessing capacity under the Comment 6 factors. By doing so, the new comment would move toward a framework that better enhances the client's ability to exercise autonomy.

5. Other Considerations and Alternative Approaches

Critics may argue that intellectual disabilities can genuinely undermine decision-making ability and that lawyers should intervene to protect clients who are vulnerable to harm, exploitation, or self-destructive decisions. Some scholars have explained that functionally incompetent individuals are *entitled* to paternalism, because they are likely to suffer harms that they have not chosen themselves.[102] This is an important consideration to maintain the integrity of the client-lawyer relationship, because some level of intervention must be permitted to assist those who are truly incapable of helping themselves.[103] For example, the court in *Eugster*

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[101] *See* Helmchen et al., *supra* note 12 at 39 (citing CRPD Committee 2014).

[102] Tremblay, *supra* note 71 at 536.

[103] *Id.* at 583.

expressed particular concern regarding elderly individuals with dementia that may fall under the influence of a friend, neighbor, or distant family member that may not want the best for them.[104] However, research suggests that patients with dementia often present cognitive fluctuations, rather than complete decision-making impairment.[105] Therefore, researchers in the healthcare decision-making space suggest that capacity should be assessed on a situation-specific basis and continually revisited throughout the development of the disease.[106]

In certain situations, it may be necessary for a lawyer to question the decision-making capacity of a client. However, if a client can communicate their preferences to the lawyer, then the lawyer should honor that to the best of their ability.[107] Rule 1.14 already allows the lawyer to take protective action.[108] Making the proposed changes and additions to Comment 6, and adding a new comment that encourages lawyers to implement supported decision-making interventions before evaluating capacity does not eliminate this possibility of lawyer intervention for protective action. Rather, it raises the threshold to override client autonomy. The legal system already routinely respects autonomy even when decisions appear to be risky or unwise, because

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[104] *See Eugster*, 209 P.3d at 452 ("[O]ne scenario that is regrettably not uncommon is for a person of advanced years to fall under the influence of a friend, neighbor, or distant family member. It may come to the attention of a lawyer that an impaired client has fallen under such influence. Often, the friend or distant family member has taken the client to his or her own lawyer who has prepared a new will cutting out other family members and frustrating careful estate planning. Under such circumstances, if the lawyer reasonably believes that her client is suffering diminished capacity and is under undue influence, the lawyer may take protective action under RPC 1.14 without fear of provoking charges of ethical misconduct by the WSBA seeking disbarment").

[105] Ana P.S. Amaral et al., *Capacity Assessment Instrument – Health: Pilot Study of a New Tool for Adults with Dementia*, 48(3) Clin. Gerontologist 411, 412 (2024), https://www.tandfonline.com/doi/full/10.1080/07317115.2024.2331171.

[106] *Id.* at 412.

[107] David Luban, *Paternalism and the Legal Profession*, 1981 Wis. L. Rev. 454, 493 (1981).

[108] Model Rule 1.14, *supra* note 4 at (b).

this is the bedrock of living in a free and democratic society.[109] For example, courts already allow defendants in criminal cases to waive counsel, even when doing so is seemingly risky.[110] The proposed changes in this paper further the foundation of our democracy, while leaving the safeguards of Model Rule 1.14 intact for cases in which protective action is truly needed.

Alternative approaches to Rule 1.14 improvements have been proposed by others, as well.[111] One alternative approach is to use the approach of physicians obtaining informed consent to amend the Comment 6 factors to be more objective.[112] Another alternative approach is to require confirmation of diminished capacity by a mental health professional in cases where a lawyer does determine that a client has diminished capacity.[113]

6. Conclusion

Considering history, ethics, and scientific research, Rule 1.14 should be updated to minimize wrongful paternalism for persons with disabilities. Misinterpretations about capacity have historically harmed people with disabilities, with effects ranging from underrepresentation to persecution.[114] Model Rule 1.14 currently gives lawyers the power to override clients that they perceive as having diminished capacity, in effect diminishing the autonomy of those clients.[115]

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[109] *See* Dinerstein, *supra* note 69 at 513.

[110] *See Faretta v. California*, 422 U.S. 806, 836 (1975) (holding that the defendant's technical legal knowledge was not relevant to his knowledge of the right to defend himself, and that the lower court deprived him of his constitutional right to conduct his own defense when they forced him to accept a state-appointed public defender).

[111] *See* Harp, *supra* note 5.

[112] *Id.*

[113] *Id.*

[114] Disability Rights Timeline, *supra* note 28.

[115] *See* Model Rule 1.14, *supra* note 4.

The effects of paternalism harm more than just the individual who has their autonomy removed; they also harm the client-lawyer relationship, endangering the integrity of the legal profession.[116]

While Comment 6 provides a list of factors that attempt to aid lawyers in making well-rounded assessments of client capacity, neuroscience reveals that the current factors are too vague and subjective to account for the complexity and variability of decision-making.[117] Especially in light of recent neuroscience research that reveals the effects of personality traits and emotions on decision-making, it is important to consider that there are different ways in which people may reach a rational decision.[118] This paper has proposed the following interventions: 1) specific revisions to the factors of Comment 6, taking neuroscience research into account; 2) an addition to Comment 6 that encourages lawyers to self-reflect on their own biases when using the Comment 6 factors to assess capacity; and 3) addition of a new Comment to Rule 1.14 that would encourage supported decision-making interventions listed in the CRPD before assessing client capacity using the Comment 6 factors. Without implementing this paper's proposed changes to Rule 1.14, the legal profession risks perpetuating a long history of denying decision-making authority to those with cognitive or behavioral differences.[119]

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[116] Sabatino, *supra* note 54 at 489-90; Christine Bigby & Alan Hough, Disability Practice: Safeguarding Quality Service Delivery 203, ch.11 Christine Bigby, *The Right to Participate in Decision Making: Supported Decision Making in Practice* (2024).

[117] *See* Model Rule 1.14, *supra* note 4 at Comment 6; Macpherson et al., *supra* note 15 at 2.

[118] Crivelli et al., *supra* note 45.

[119] Disability Rights Timeline, *supra* note 28; *Buck v. Bell*, 274 U.S. 200, 584 (1927).