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REFLECTIONS ON DETERMINING COMPETENCY

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ABSTRACT

Psychiatrists are the health care professionals most frequently called upon to determine the competency of a patient to refuse treatment. The motives for determining competency vary in morally significant ways. This paper explores what I term 'the ideal motivational situation' for determining a patient's competency: a desire to respect the patient's autonomy, a desire to promote the patient's overall best interests, and a belief that when these two motives conflict the patient's autonomy should not be dismissed out of hand as a partial patient interest which is naturally outweighed by the totality of his or her interests. I claim that in a liberal, democratic society autonomy ought to trump best interests and be the sole criterion of patient competence. I conclude by offering an essentially aesthetic criterion for determining autonomy.

THE PROBLEM

Psychiatrists must often determine the competency of uncompliant patients:

> Dear Messrs. Rosencrantz and Guildenstern:
> Thank you for asking me to see Prince Hamlet. Patient is a 30 year old white male who has undergone a radical change of behavior since his father's death four months ago. This initially manifested itself as a marked dysphoria. Patient admits to having lost all mirth, foregone all customary exercise and perceives the whole world as nothing but a foul and pestilent congregation of vapors. He takes no delight in man or woman and considers the world a prison. Where previously he had been the glass of fashion, he now dresses in a disheveled state, with his doublet all unbraced, no hat upon his head, his

stockings foul, ungartered and down to his ankle. Patient appears obsessed with suicidal ideation, referring to the possibility of suicide as 'the question.' He has expressed regret that the Everlasting has fixed his canon against self slaughter. Patient wishes that his flesh would melt, thaw and resolve itself into a dew. He finds the world weary stale and unprofitable and appears to believe his death is a consummation devoutly to be wished.

Manic tendencies are also present. At times the patient's speech is wild and whirling. He has expressed the view that the world is out of joint and that he was born to set it right. Patient speaks loudly, flippantly and vulgarly at theatrical performances where he is unable to contain his excitement. Patient puns compulsively.

Patient's speech also abounds with non sequitors and other forms of loose associations. When told his mother wishes to see him he replies 'your welcome' and goes in one sentence from talking about Maggots and God kissing carrions to inquiries about his interlocutor's daughter.

Patient has at times failed to recognize people well known to him. Once he mistook an elder statesman of the court for a fishmonger. His mother reports he has visual hallucinations, claiming to see the ghost of his father in her bedchamber.

Patient has flown into uncontrolled, paranoid, violent rages on a number of occasions. He has screamed at his girlfriend to go to a nunnery, shook his mother while imploring her to avoid sex with her husband, and impulsively murdered a man he couldn't even identify, yelling 'How now? A rat? Dead for a ducat.'

The patient seems to have some insight into his illness. He confesses that his wit's diseased, but maintains that he is but mad 'north- north-west.' and that when the 'wind is southerly,' he 'knows a hawk from a handsaw.'

Impression: Patient is suffering from Schizoaffective Disorder, Bipolar type secondary to complicated bereavement leading to homicidal and suicidal tendencies.

Recommendation: Patient is clearly not competent to make rational decisions about his treatment, and so even though he desires to remain in Denmark, I recommend he be committed to England.

Thank you.

Sherman Peabody, MD

While having some unusual, we might even say dramatic features, in one way the case of Hamlet (at least in my loose reconstruction of it) is typical of the most common circumstance in which we attempt to determine competency; we are confronted with a patient who refuses to go along with a recommended course of treatment.[1]

There are other circumstances giving rise to claims of incompetency, but they tend to be epistemically untroubling (there are no puzzles in figuring out whether or not the patient is incompetent) and therefore, with regard to issues of competency, ethically untroubling. With comatose patients and with infants the incompetency is unquestioned. While cases involving such patients do raise many ethical issues, the issues do not stem from questions about competency; rather it is the clear absence of competency which generates many of the dilemmas of these cases, such as, who should make the decisions for these clearly incompetent patients. Nor is the question of competency particularly problematic when the patient and health care providers agree on a course of treatment. In such cases we may wonder whether a patient is competent to give valid informed consent – and if the patient's relatives are against the treatment that was recommended and agreed to by the patient, there may indeed be sticky questions of competency. But for the most part, when patient and reputable doctor agree on what's to be done, we've little motive to inquire into the patient's competency, we seldom extend great efforts to determine it, and rarely are morally troubled by it.[2] The circumstances I will discuss are those in which the health care practitioners recommend something to a patient and the patient does not want it done. Under these circumstances the only way the practitioners can implement their recommendation is if the patient is judged incompetent.

The first question I will address is why the practitioners care about implementing their recommendation – that is, what motivates them to try to determine competency? One of the charms of Tom Stoppard's play *Rosencrantz and Guildenstern are Dead* is that it causes us to reassess our views of Rosencrantz and Guildenstern's moral character by speculating on their motives for determining Hamlet's sanity. But it is not only Rosencrantz and Guildenstern who are interested in Hamlet's sanity. A central

[1] Hamlet actually doesn't refuse, but it would have been imposed on him in any event.

[2] A major exception is the area of human experimentation. There, patient-physician concurrence does not quiet moral concern regarding competence.

concern of many of the characters in *Hamlet* is the mental status of the Prince. Claudius, Gertrude, Polonius, Ophelia, as well as Rosencrantz and Guildenstern and Hamlet himself – all are interested in determining if Hamlet is mad. If he is mad, they what to know the cause of his madness, i.e. what sort of madness they are dealing with. But if we try to assess the rationality or morality of how they go about their task of assessment, we will find that we cannot use a common standard. For each character has a very different motive for trying to assess Hamlet's mental status. They go about their tasks in different ways, not because they attended different residency programs or adhere to different psychiatric theories, but rather because they have different reasons for making the inquiry. They all have the same basic question – is Hamlet mad, and if he is, why? But the king wants to know to determine if Hamlet is a threat to him, the Queen wants to determine how to treat him effectively, perhaps in order to assuage her guilt over her quick remarriage, Polonius wants to gain favor at court and through his daughter gain advancement for the family, Ophelia wants to judge her romantic prospects and is genuinely concerned for her beloved, Rosencrantz and Guildenstern are obedient to a royal command, whether out of fear of punishment, hope for reward, or sense of patriotic duty we cannot say. How they all go about their common task of determining Hamlet's competency and whether they do it sensibly and ethically we must judge in the light of their reasons for doing it. And so too when we judge psychiatric inquiries into competency.

Why do health care professionals want to determine the mental competence of patients? This question is seldom asked and when it is the question is usually perfunctory. This is so because the answer seems obvious and uncontroversial. And to a certain extent that is true. The *ideal* answer is rather obvious and uncontroversial: we value a patient's *autonomy* and if they are capable of exercising it, we want patients to make the ultimate decisions about their health care, or, at the least, we want to give great weight to their autonomous will when those decisions are made.

But does this idealized answer exhaust the actual motives health care providers bring to the task of determining competency? Is it the motive common to the various kinds of health care workers: doctors, nurses, allied health professionals, hospital administrators?

MOTIVES FOR DETERMINING COMPETENCY

Just what health care practitioners' motives actually are when they attempt to determine competency is a question open (to some extent) to empirical inquiry. I have not made those inquiries. But I will speculate on a few possible motives to illustrate how different motives might give rise to different approaches in determining competency.

One reason health care professionals may want to determine competency is because it is illegal to treat a competent patient against her will. Avoidance of liability is a motive distinct from promotion of autonomy and can lead to distinct actions. In particular it can lead to non-substantive formal procedures – a sort of going through the motions. What's important is that one has the right documentation, the right witnesses and a plausible rationale for treating the reluctant patient.

A second motive might be health care practitioner convenience. A patient who can be restrained against her will is less of a management problem then one who wanders, pulls out IV tubing or refuses to remain in the quiet room. Obviously if your motive for figuring out whether a patient is competent is to see if you can legitimately treat her in a way that makes your work easier, your assessment of her competency will be heavily influenced by just how disruptive her behavior is – a factor which might be quite irrelevant to the patient's capacity for autonomous behavior.

Practitioner convenience might cut the other way. Often, it is a difficult task to impose a treatment on a resisting patient. The easiest thing to do is to judge the patient competent and to honor her refusal of treatment. How are our judgments of competency affected by the knowledge that a finding of incompetence is going to lead to an unpleasant struggle and a good deal extra work? No doubt it would incline us to a more generous and elastic definition of competency.

Sometimes health care providers seek a finding of incompetency out of empathy for a family that wants one of its members to undergo treatment that the individual refuses.

Even when the psychiatrists responsible for determining competence are not directly motivated by any of the above considerations, the concerns of others – others who may have requested the competency determination and are a source of information about the patient – can influence and shape their deliberations

I have catalogued some possible motives for determining competency not in order to question the integrity of health care

practitioners. Honest and good people invariably have complex and mixed motives when making difficult judgments of practical import. But intellectual and moral clarity demands that we recognize these motives. I leave for another occasion whether any of them ought to be completely suppressed and allowed no role in our deliberations concerning competency, or whether these non-patient centered motives ought to be frankly acknowledged as legitimate considerations when judging competency, in spite of their theoretical irrelevancy to a strictly construed question about a patient's capacities.

Having acknowledged the range of actual motivations for determining competency, I want to turn to what I call the ideal motivational situation for seeking to determine a patient's competency, namely, a desire to respect the patient's autonomy, a desire to promote the patient's welfare, and a belief that when these two motives conflict the patient's autonomy should not be dismissed out of hand as a partial patient interest which is naturally outweighed by the totality of her interests. Therefore, we desire to determine competency to see whether 1) in fact autonomy is present, and/or 2) the patient, although autonomous, is employing judgment too dangerous to his welfare to merit respect.

This formulation is an oversimplification. The relationship between patient autonomy and patient welfare is not so distinct. Some would argue that a patient's welfare is always best served by respecting her autonomy and others would claim this is true for at least all practical purposes. Conversely, there are those who would maintain that when a person is not doing what's in her best interests, then by that very fact she is not acting autonomously.

From different directions both these approaches tend to collapse the distinction between a patient's welfare and her autonomy. One claims you act autonomously only when you act in your best interests, the other claims that whenever you act autonomously you are acting in your best interests. There is something to be said for each approach. But they try to dissolve the moral dilemma that underlies the search for competency rather than confront it. For the real problem of competency comes up when we acknowledge that the patient's welfare is distinct from her autonomy, and that if we respect her autonomy we likely will allow her welfare to suffer. Of course there is no conflict if the patient is incapable of exercising autonomy, i.e. there is simply no autonomy there to respect. Hence one of the core conceptual questions we face when determining com-

petency is 'Does this patient have the capacity to act autonomously?' We shall return to it later. But first I want to describe the potential conflict between the value of patient well being, that is the value of promoting the patient's best interests, and the value of patient autonomy.

Wherein does the value of autonomy lie? Let us start off by defining autonomy common sensically as the ability to make decisions concerning what you do and what others do to and for you (later we will revise and deepen this definition). In so far as you make decisions in these areas you are autonomous. Now what is valuable about that? There are, broadly speaking, two types of answers: one is that autonomy has great instrumental value, the other is that autonomy has great intrinsic value. In the first case the claim is that autonomy is valuable because it is an essential, or at least an especially useful, instrument for obtaining other valuable things, while in the second case it is maintained that autonomy is good in and of itself, that is, it has important value whether or not it happens to entail other goods.

Although autonomy clearly has instrumental value, I also take it to have great intrinsic value – leading your own life is good in and of itself – which means that the value of autonomy can conflict with other values, e.g. health, wealth, reputation, etc. These other values may be interests of the patient that outweigh the patient's interest in autonomy. In such cases it is in the patient's best interests not to be allowed to act autonomously, for his autonomous action would lead to a 'bad' decision, i.e. not a decision that will be in his overall best interests. Understanding autonomy as having intrinsic values creates a moral problem when a patient's autonomy clashes with her best interests.

A CRITERION FOR AUTONOMY AND A STANDARD OF COMPETENCY

If we don't dissolve the problem by equating autonomy with the capacity to make a good (i.e., best-interest promoting) decision, we must accept that you can exercise consistently 'bad' judgment and still be autonomous. It is only when you are no longer capable of making any decision about your life, good or bad, that you become incapable of autonomy. I want to emphasize that I am speaking here of *you* making a decision about your life. It is not enough that your body or some fragment of your mind seems to indicate an inclination. While autonomy doesn't require that you make good decisions, it does require that the decisions that you make are genuinely *yours*. And because, *ex hypothesi*, our

motive for determining competency is the great value we put on autonomy, the standard of competency we ought to employ is as follows: is the person making her own decision, is she shaping, however well or badly, her own life. If she is, she is competent, because she can be autonomous. The incompetent is the person who cannot, either temporarily or permanently, exercise autonomy.[3]

Now even if we adopt this standard we have not cleared up the philosophical, let alone the practical questions regarding competency. After all how do we determine that a person *is* making her own decisions? Making a decision is not the same as having or expressing a preference, or even the same as acting on a preference. All of that can be done by plants, animals, and infants, none of whom make decisions. What, then, are the minimal conditions that must be met in order for a person, to qualify as an agent, as a shaper of her own life? What makes a particular decision *your* decision, a particular action *your* action.

WHAT ARE *YOUR* ACTIONS: A ROUGH SKETCH

In our legal tradition you are responsible for a crime if you understand what it is that you are doing, and can distinguish right from wrong. The application of this standard is notoriously vague, subjective and difficult. I don't think it is of much help to us. I think it is both too strong a standard, and not strong enough. I think there are cases when you don't fully understand want you are doing, don't quite comprehend the consequences of your action, but it is still your action. Sometimes you don't realize just what you are getting yourself into, but still it is you getting yourself into it. Perhaps that's the way most of us get married or have children. On the other hand, intellectual clarity on the causes and effects of your behavior is not sufficient to make that behavior your act. You might know what 'you' are doing, but if you can't control the behavior, it isn't your act. Or if the behavior comes from something that is not a part of your personality, it is not your act. Dr. Jekyl was not responsible for Mr. Hyde's actions, nor should we honor Mr. Hyde's health care

[3] Note that this standard of competency contrasts with standards of competency that make competency relative to a specific task (T. Beauchamp. 1991. Competence. In *Competency: A Study in Informal Competency Determinations in Primary Care*. Mary Cutter and Earl Shelp, eds. Dordrecht, Netherlands. Kluwer: 50–77) or to a specific task/situation (A. Buchanan and D. Brock. 1989. *Deciding for Others: the Ethics of Surrogate Decision Making*. Cambridge. Cambridge University Press.)

decisions concerning the treatment of Dr. Jekyl. And that is so even if Dr. Jekyl understands what Mr. Hyde is doing. If autonomy is control of your own life and competency should be acknowledged in all those capable of autonomy, then we should deem competent all those who have a self and whose self issues in actions. A particular decision should be viewed as competently made if it flowed from the person and not from some feature accidentally associated with her, forming no real part of her.

There is no formula for determining what genuinely flows from a person's self. Perhaps it can't be done unless you know the person reasonably well. Moreover, realistically speaking, we are confronted with a continuum on this matter, rather than an all or nothing affair. Things come more or less from your self. While some actions and decisions may be typical of you and are an obvious outgrowth of your personality, others may be 'out of character' but still very much belong to you. Just because a decision seems to be unlike you doesn't mean it isn't your decision. After all, you can undergo some pretty radical changes, be a 'changed person' in fact, but still be capable of autonomy. We ought to lean heavily toward the presumption that patients are autonomous, that the decisions which they appear to be making, they actually are making. Only if we judge that a person has no self, that her self has disintegrated, or that the particular decision she seems to be making could not possibly come from who she is or who she might have possibly become – only then should we judge autonomy to be impossible and only then should we consider her incompetent. This is a very strict standard to meet. A patient doesn't meet it by simply being emotional, or illogical, or ill informed or somewhat confused. He certainly doesn't meet it by being a pain in the ass. He only meets it by not being himself in any of his manifestations. More of this later.

ALTERNATIVE APPROACHES: COMPETENCY WITHOUT AUTONOMY OR COMPETENCY WITHOUT AUTHORITY

If we see autonomy as of *overriding* value and as definitive of competency, then if you are autonomous you are competent, and if you are competent your decisions should be respected. End of story.

If, however, we think of autonomy as of great, but not always overriding value, we have two rhetorical choices: we can deny that the competent person ought to always have her wishes respected. Call this 'competency without authority', or, if we wish to retain 'competency' as *the* feature conferring decision-making authority

on a patient, we can redefine 'competency,' so that even autonomous persons can be deemed incompetent. We may choose to call a person incompetent who, although autonomous, has such poor judgment that she makes grossly wrong decisions, decisions, which if honored, will do her serious harm. The incompetents under this definition are people who have no or little chance of making a *good* decision. Note I am not saying the incompetent is a person who in a particular instance is making a very bad decision; that would be to reduce incompetency to mere disagreement with the consensus of professional opinion. I am saying that incompetency can be defined as the inability to make good decisions with a modicum of reliability, that is, with better than random odds that the decision will come out right. In this sense competency becomes relative to the task at hand. Under this standard, I am presently incompetent to fly a plane – there is no reasonable chance that I will fly the plane well, and every likelihood that if my desire to fly a plane was indulged I'd do myself serious harm. This definition is closer to the everyday usage of incompetency when we say someone is 'incompetent' to do something.[4] And if it is something that they don't have a right to do, it makes sense not to allow them to do it. On these grounds I should not be allowed to fly, perform open-heart surgery, teach Japanese literature or sing lead tenor at the Metropolitan opera. I cannot do any of those tasks reasonably well and relative to those tasks I am incompetent.

But I would argue that no amount of these relative incompetencies should amount to rendering a person incompetent in the relevant sense we are discussing; incompetent to make decisions that normally *everyone has a right* to make. That sort of competency should not depend on your ability to make the decision well, but simply on your ability to make it at all. Health care professionals do have to make judgments about relative capacities and some plans of care should be based on those judgments. But for the bottom line decision of whether we ought to honor someone's refusal of treatment, I think the appropriate standard is capacity for autonomy. It is mischievous to define competency as involving more than autonomy, or granting less than decisive personal authority.

The 'autonomy only' standard for competency I am extolling (where 'autonomy' does not imply a capacity to make *good*

[4] It is also the notion of competency that is the 'common view' of bioethicists. (R. Wettstein. 1995. Competence. In *Encyclopedia of Bioethics*. W. Reich, ed. New York. McMillian. I: 447)

decisions) is intended to raise the bar for judging someone incompetent. But such a standard is easily open to abuse, and through easy metaphors, can actually lower the standard. Properly applied the standard would judge someone competent if it is she who is making the choice rather than something about her, something that is not really part of her self, that is making the choice. But it is very easy to say things like 'that's not Barbara, that's the alcohol talking', or 'that's not the sort of thing that Ed would ever want'. In fact there is a long history in political theory of justifying undemocratic regimes because they serve the needs of the people's 'true selves,' rather than their apparent selves. The proposed standard certainly opens the way for justifying health care tyranny with a similar appeal to true selves. But merely because an approach can be abused is no evidence that it is incorrect. I feel that competency, the right to run your own life, really should be based on nothing more than your capacity to run your own life, not your capacity to do it well. If we stick to this standard, it means that we will often sacrifice a person's overall well being for the sake of her autonomy. It seems to me that is the right choice in a liberal democratic society.

TALES OF AUTONOMY

I have suggested ('argued' is too strong a word for these reflections) that we retain 'competency' as the attribute entitling a person to make her own treatment decisions, and that competency be regarded solely as a function of the capacity for autonomous action. Autonomous action, in turn, has been characterized as action that flows from the self. So the reader has a right to ask for an account of 'action that flows from the self,' before entertaining the possibility that anything of much use has been said. Here I will candidly employ circularity that, I hope, I can redeem from viciousness. Autonomy arises from a self, and a self arises from autonomy.

Ever since Hume labeled the self a sort of fiction,[5] philosophers and psychologists are increasingly converging on views of 'the self' as an historical and social construction, a complex of psychological events, with no single natural adhesive or locus. The self is not an objective, naturally (i.e., pre-culturally) given entity. It is, as the standard cliché for this sort of thing puts it, created, not discovered.

[5] There are earlier expressions of this general view: we can note the Buddha's denial of the self's reality.

The self is a posit, a theoretical entity used to unify diverse phenomena into an explanatory scheme. Its nature is best understood by understanding why it is created, what, that is, we are trying to explain with the creation of the self. Different cultures are interested in explaining different things and therefore create different sorts of selves, if indeed they create any selves at all. What do we, inhabitants of liberal 21st century Western culture, want to explain?

Our selves are meant to explain autonomous action. The self is that which makes autonomous action possible. Without a self we are left with a stream of psychological events without a theme, a goal, a protagonist, a meaning or a subject. Each self is an attempt to arrange the psychological hodgepodge into a meaningful story. And the story form we most value is a story of freedom, a story of autonomy.

Free action is not fully predictable and is not coerced. But it is not a random spasm either. In *retrospect* we see how it is connected to and flows from earlier states and acts. Because of the complexity and subtlety of cross and recursive influences, we could never confidently have predicted the act, nor can we with certainty, even in retrospect, specify all of its necessary and sufficient conditions. But in retrospect we can make sense of the act. We look back on the series to which it belongs and see what purposes it serves, or can be thought of as serving. We give Hume's bundle goals, projects, purposes – a life of its own. The bundle becomes self directed, free, autonomous. The self is the theme, the 'subject' of a story, a story we choose to view as writing itself.[6] Nietzsche has called us free artists of ourselves. But a self is at least as much the artist others assume to exist, the artist who is creating the human life we choose to see as a free creation. The self is an interpretation, finding its acts is an act of aesthetic criticism.

The search for competency is a search for a meaningful continuation of the story of a self. A meaningful continuation doesn't preclude sudden and dramatic plot twists, or wholesale

[6] Kant equated this freedom with the ability to act rationally – as if rational action were the only meaningful arrangement of our acts. A Kantian view denies the compatibility of autonomy and bad decisions. Kant had a narrow view of what makes a good story. But in a fundamental way, Kant agrees with the view that the self is the explanatory posit that makes autonomy possible, and that autonomy is coherent expression of a theme. It is just that Kant insisted that rational consistency and the recognition of others as metaphysical equals were the only coherent themes. However morally noble, equating the categorical imperative with freedom is aesthetically narrow.

reinterpretations of what the story up till now has meant. So long as we can make a good autonomous story out of it, we have found a self to serve as the author of the autonomy.

If we really value autonomy we should strive to find it wherever possible. The only incompetents are those for whom our best interpretive efforts fail to construct a plausible story of freedom; no story can be made to hang together, none can be made of a piece with the story up to now. We should declare incompetency only when all of the available explanations of the behavior we are confronting are either accounts of the mechanical playing out of fully comprehended forces, or the statistical playing out of unmeaningful chaotic randomness. In either case we lack a story of human action. The human story, of course, can contain both predictable mechanical forces and chaotic randomness, indeed the natural phenomena that serve as raw material for the story is undoubtedly composed entirely of such random and mechanical elements, and even on the narrative level, such elements continue to exist. But in their unfathomable interplay, the elements become a whole that transcends all of sub-narrative explanatory genres. We make a story out of them.

We return to Hamlet. He is competent, with a vengeance (pun acknowledged but unintended.) The only reason anyone has even been tempted to declare him incompetent is because his remarkable human freedom allows for *too many* plausible stories. There appear to be endless meaningful interpretations of his behavior. We know that Hamlet's behavior has of late undergone a radical alteration, but we are sure the alteration isn't a random event, or the predictable result of an identifiable determinative natural law. But there is no consensus as to what his true story is. If we could all settle on the story explaining Hamlet's behavior, as we can with the behavioral change of Ebenezer Scrooge, we would have little difficulty seeing him as competent. Not that Scrooge's change was inevitable – if Dostoyevsky wrote a Christmas Carol, Scrooge might have continued to hate Christmas out of spite – but the story lends itself to a standard, familiar interpretation. We don't think either the pre-spirit visitation Christmas-hating, nor the post spirit-visitation Christmas-loving Scrooge is mad. Scrooge was and is responsible for Scrooge. He is competent.

If anything Hamlet is more competent than Scrooge. We are sure that everything he does flows from who he is. No character is more complex, less predictable: none evinces a more robust autonomy. But of course none of that is true without readers and theater audiences willing and able to interpret Hamlet's

behavior. Nor will it be true if the complexity of the behavior and the cornucopia of plausible interpretations lead overwhelmed observers to deny Hamlet's freedom rather than confront its profundity.[7]

In determining competency then, we should ask ourselves two questions: The first is what is our motive in finding out? If it is because we truly value autonomy, as a liberal democratic society rightly does, then we must engage in a collaborative effort, with colleagues, family members and the patient to create the autonomy, to find an interpretation of human behavior that recognizes a self in it.

This task leads to the second question, 'what is the self that might be the autonomous author of these actions?' This second question is starkly and simply put in the opening line of *Hamlet* – 'Who's there?'

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[7] It is interesting that one of the themes in *Hamlet* revolves around the question of the nature of our true selves, and especially Hamlet's true self. Indeed when apologizing to Laertes Hamlet himself says 'What I have done . . . I hereby proclaim was madness. Was't Hamlet wronged Laertes? Never Hamlet, If Hamlet from himself be ta'en away, and when he is not himself does wrong Laertes, then Hamlet does it not, Hamlet denies it. Who does it then? His madness.' I don't think Laertes buys it, and neither do we.