Special Communication

Reprinted from the Journal of the American Medical Association
August 17, 1984, Volume 252

Competency to Give an Informed Consent

A Model for Making Clinical Assessments

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• A patient's decision must be informed and free, and he/she must be competent either to consent to or refuse treatment. Rather than selecting a single standard of competency, a sliding scale is suggested that requires an increasingly more stringent standard as the consequences of the patient's decision embody more risk. The standard of competency to consent to or to refuse treatment depends on the dangerousness of the treatment decision. Three different standards are correlated with the psychiatric abnormalities that are most likely to undermine them. A model with guidelines for use is provided to aid the physician who is called on to make a determination of competency.

(*JAMA* 1984;252:925-927)

IN JANUARY 1980, as one more indication of the growing importance of medical ethics, a presidential commission was formed and began work on the moral questions posed by the practice of contemporary medicine. After three years of intense work, the commission published a separate volume on 11 different ethical problems in the hope of stimulating thoughtful discussion. Some broad principles were uncovered that apply to any and every bioethical issue, such as the principle of patient respect and its concrete application in the right of informed consent. But there were also recurring perplexities, one of which was competency or, in the language preferred by the commission, the patient's capacity to choose.[1]

Respect for patients means ensuring their participation in decisions affecting their lives. Such participation is a basic form of freedom and stands at the core of Western values. But freedom, participation, and self-determination suppose a capacity for such acts. No one, for example, assumes that an infant has such a capacity and, time and again, doubts arise about the capacity of some older patients. Not to respect a patient's freedom is undoubtedly wrong. But to respect what may be an expression of freedom only in appearance would be a violation of another basic principle of ethical medicine: promotion of the patient's well-being.

Although the commission's report referred many times to competency or capacity to choose, commissioners and staff members privately expressed frustration and disappointment about their conclusions. The commission reports spelled out what are considered to be the components of competency: the possession of a set of values and goals, the ability to communicate and understand information, and the ability to reason and deliberate. In addition, the commission criticized some standards for determining competency that either were too lenient and did not protect a patient sufficiently or were too strict and in effect transferred decision making to the physician. But the commission did not come up with its own standard and left unsettled the question of how to decide whether a particular patient's decision should be respected or overridden because of incompetency. Incompetency is not the only reason for overriding a patient's refusal or setting aside a consent, but it is the most common reason for doing so. Defining incompetency or establishing standards of competency is a complex problem because it involves law, ethics, and psychiatry.

COMPETENCY ASSESSMENT

Competency assessments focus on the patient's mental capacities, specifically, the mental capacities to make an informed medical decision. Does the patient understand what is being proposed? Can the patient come to a decision about treatment based on an adequate understanding? How much understanding and rational decision-making capacity are sufficient for this particular patient to be considered competent? Conversely, how deficient must this patient's decision-making capacity be before he is declared incompetent? A properly performed competency assessment should eliminate two types of error: (1) preventing a competent person from participating in treatment decisions and (2) failing to protect an incompetent person from the harmful effects of a bad decision.

MODEL FOR MAKING THE ASSESSMENT

The President's commission did not recommend a single standard for determining competency because any one standard is inappropriate for the

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many different types of medical decisions that people face. What is proposed here is a sliding standard, ie, the more dangerous the medical decision, the more stringent the standards of competency. The basic idea, following a suggestion of Mark Siegler,[2,3] is to connect determination of competency to different medical situations (acute or chronic, critical or noncritical), and next to take this idea a step further by specifying three different standards or definitions of what it means to be competent. These standards are then correlated with three different medical situations, each more dangerous than the other. Finally, the sliding standards and different medical situations are correlated with the types of psychiatric abnormalities that ordinarily undermine competency. The interrelationship of all these entities creates a model that can aid the physician faced with a question about a patient's capacity to choose. This model brings together disparate academic disciplines, but its goal is thoroughly pragmatic: to provide a workable guide for clinical decision making.

Standard 1

The first and least stringent standard of competency to give a valid consent applies to those medical decisions that are not dangerous and objectively are in the patient's best interest. If the patient is critically ill because of an acute illness that is life threatening, if there is an effective treatment available that is low in risk, and if few or no alternatives are available, then consent to the treatment is prima facie rational. Even though patients are seriously ill and thereby impaired in both cognitive and conative functioning, they are usually competent to consent to a needed treatment.

The act of consent to such a treatment is considered to be an informed consent as long as the patient is aware of what is going on. *Awareness* in the sense of orientation or being conscious of the general situation satisfies the cognitive requirement of informed consent. *Assent* alone to what is the rational expectation in this medical context satisfies the decisional component. When adult patients go along with needed medical treatment, then a legal presumption of competency holds even though the patients are obviously impaired. To insist on higher standards for capacity to give a valid consent in such a medical setting would amount to requiring surplus mental capacities for a simple task and would result in millions of acutely ill patients being considered incompetent. Such an absurd requirement would produce absurd consequences. Altogether rational and appropriate decisions would be set aside as invalid, and surrogate decision makers would have to be selected to make the same decision. For what purpose? To accomplish what objective? To protect what value? None of the values and objectives meant to be safeguarded by the competency requirement is disregarded or set aside by a lenient standard for this type of decision.

Considering as competent seriously ill patients, even the mentally ill, who are aware and assent to treatment eliminates the ambiguity and confusion associated with terms such as *virtually competent, marginally competent,* and *competent for practical purposes* that are used to excuse the commonsense practice of respecting the decisions of patients who would be judged incompetent by a more demanding single standard of decision-making capacity. Refusal by a patient dying of a chronic illness of treatments that are useless and only prolong the dying requires the same modest standard of competency.

Infants, unconscious persons, and the severely retarded would obviously fall short even of this least demanding standard. These persons, and patients who use psychotic defenses that severely compromise reality testing, are the only ones who fail to meet this first definition of decision-making capacity. Children who have reached the age of reason (6 years or older), on the other hand, as well as the senile, the mildly retarded, and the intoxicated, are considered competent.

The law considers 21 and sometimes 18 years to be the age below which persons are presumed incompetent to make binding contracts, including health care decisions. The President's commission, however, endorses a lower age of competency, and so do many authors who write about children and mental retardation. In this model, we are discussing ethical standards, but the physician cannot ignore the law and must obtain consent from the child's legal guardian.

Standard 2

If the illness is chronic rather than acute, or if the treatment is more dangerous or of less definite benefit (or if there are real alternatives to one or another course of action, eg, death rather than lingering illness), then the risk-benefit balance is tipped differently than in the situation described in the previous section. Consequently, a different standard of competency to consent is required. The patient must be able to *understand* the risks and outcomes of the different options and then be able to *choose* a decision based on this understanding. At this point, competency means capacity to understand the real options and to make an understanding decision, a higher standard than that required for the first type of treatment choice.

Ability to understand is not the same as being able to articulate conceptual or verbal understanding. Some ethicists assume a rationalist epistemology and reduce all understanding to a conceptual or verbal type. Many, in fact, require that patients literally remember what they have been told as a proof of competence. Understanding, however, may be more affective than conceptual. Following an explanation, a patient may grasp what is best for him with strong feelings and convictions, and yet be hard pressed to articulate his understanding/conviction in words.

Competency as capacity for an understanding choice is also reconcilable with a decision to let a trusted physician decide what is the best treatment. Such a choice (waiver) may be made for good reasons and represent a decision in favor of one set of values (safety or anxiety reduction) over another (independence and personal initiative). As such, it can be considered as informed consent and creates no suspicion of incompetency.

Ignorance or inability to understand, however, undermines competency. The same is true of a severe mood disorder or severe shock, which may either impair thought processes

or undermine capacity to make an understanding choice. Short-term memory loss, delusion, dementia, and delirium would also render a patient incompetent. On the other hand, mature adolescents, the mildly retarded, and persons with some personality disorders would be competent to make this type of decision.

Standard 3

The most stringent and demanding standard of competency is reserved for those decisions that are very dangerous and fly in the face of both professional and public rationality. When diagnostic uncertainty is minimal, the available treatment is effective, and death is likely to result from treatment refusal, a presumption is established against refusal of consent to treatment. The medical decision now is not a balancing of what are widely recognized as reasonable alternatives. Any decision other than the one to be treated seems to violate basic reasonableness. A decision to refuse treatment, then, is apparently irrational, besides being harmful. Yet, according to this model, such decisions can be respected as long as the patients satisfy the most demanding standard of competency.

Competency in this context requires a capacity to appreciate the nature and consequences of the decision being made. *Appreciation* is a term used to refer to the highest degree of understanding, one that grasps more than just the medical details of the illness and treatment. To be competent to make apparently irrational and very dangerous choices, the patient must be able to come to a decision based on the medical information and to appreciate the implications of this decision for his life. Competency of this type requires a capacity that is both technical and personal, both cognitive and affective.

Since the patient's decision flies in the face of objective standards of rationality, it must at least be subjectively critical and *rational.* A patient need not conform to what most rational people do to be considered competent, but the competent patient must be able to give reasons for his decision. The patient must be able to show that he has thought through the medical issues and related this information to his personal value system. The patient's personal reasons need not be medically or publicly accepted, but neither can they be purely private, idiosyncratic, or incoherent. Their intelligibility may derive from a set of religious beliefs or from a philosophical view that is shared by only a small minority. This toughest standard of competency does, however, demand a more rationalistic type understanding: one that includes verbalization, argumentation, and consistency.

The higher-level mental capacities required for competency to make this type of decision are impaired by less severe psychiatric abnormality. In fact, much less serious mental affliction suffices to create an assumption of incompetency to refuse a needed and effective treatment. On the other hand, however, not any mental or emotional disturbance would constitute an impairment of decisional capacity. A certain amount of anxiety, for example, goes with any serious decision and cannot make a patient incompetent. Some mild pain would not impair decisional capacity, but severe pain might do so. Even a slight reactive depression may not render a patient incompetent for this type of decision. But intense anxiety associated with mild or severe shock, and/or a mild endogenous depression, would be considered incapacitating. In fact, any mental or emotional disorder that compromises appreciation and rational decision making would make a patient incompetent. For example, persons who are incapable of making the effort required to control destructive behavior (substance abusers and sociopaths), as well as neurotic persons, hysterical persons, and persons who are ambivalent about their choice, would all be incompetent to refuse life-saving treatment. The same standard applies to consent to experiments not related to one's own illness.

CONCLUSION

Radical advocates of patient rights and doctrinaire libertarians will worry that this model shifts power back toward physicians who make competency determinations and away from patients whose choices ought to be respected. But only in situation 3 does the physician's power increase, and then only for the patient's welfare. Moreover, this loss in the patients' power never reaches the point where patients' self-determination is set aside. Patients can insist on their decision to refuse a treatment even when the physician knows that the outcome will be certain death, as long as every precaution is taken to ensure that such a decision is not the product of a pathological state.

A balancing of values is the cornerstone of a good competency assessment. Rationality is given its place throughout this model. Maximum autonomy is guaranteed for patients because they can choose to do what is not at all beneficial (a nontherapeutic experiment) or refuse to do what is most beneficial. Maximum benefit is also guaranteed because patients are protected against harmful choices that are more the product of abnormality than of their self-determination. All the values, in fact, on which competency requirements were originally based are guaranteed in this model.

No one proposal will settle the question of which standard or standards of competency are appropriate for medical decisions. More empirical research is required on the issue, and more physicians who have valuable practical experience with complex cases need to be heard from. After much more study and discussion, perhaps the medical profession itself, through its ethics committees, will take a stand on the issue. In the meantime, this proposal is meant to be a contribution to the discussion.

This investigation was supported in part by grant ED 0652-78 from the National Endowment for the Humanities.

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Printed and Published in the United States of America