

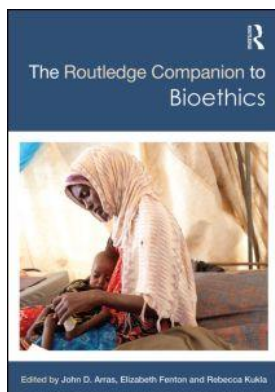
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CAPACITY AND COMPETENCE

Jessica Berg and Katherine Shaw Makielski

Introduction

The validity of a patient's informed consent to medical treatment depends on several factors, including the topic of this chapter: competency. While competent patients may make any reasonable or unreasonable choices with regard to their health care, a determination of incompetence—even temporary—severely limits a person's ability to exercise self-determination. Incompetence is sometimes referred to as a formal exception to informed consent (e.g., informed consent does not need to be sought from an incompetent patient), and other times competence is considered simply to be a core requirement for a valid consent (i.e., patients must be competent to make an informed decision). From either perspective, competence is a crucial aspect of autonomy, a term which, in the context of informed consent, may be defined as the highly valued and protected right to make independent decisions about one's body and health care. But competence is not the only determinant of autonomy. An individual may have all the capacities necessary to make an informed decision, but fail to exercise autonomy because of coercive forces that interfere with voluntariness, or due to lack of pertinent information. It is capacity, however, not other limitations of autonomy, which is the focus of this chapter.

While a competent patient may make a wide range of choices, reasonable or otherwise, with regard to his health care, a determination of incompetence—even temporary—severely limits a person's ability to exercise self-determination and make an autonomous choice. This is because the concept of autonomy requires that an individual who possesses the ability to recognize and act upon his own interests must be given the freedom to act upon those interests (or not, should he so choose). The lack of certain abilities, or capacities, interferes with the exercise of autonomy by preventing the individual from knowing his interests, from knowing the scope or import of the decision in question, or actually making a choice. There are two fundamental concerns here: identification of the abilities or capacities necessary to exercise autonomy; and identification of the means or tests by which to determine the presence of those capacities. Beyond these two questions, there are also practical issues related to applying various tests of capacity, and what to do when someone is found to lack capacity. This chapter outlines basic concepts for understanding patient competence and incompetence, and explores some key areas of ongoing debate, including setting competence standards, identifying mechanisms for determining capacity in different situations, and recognizing the capacity of minors. It focuses on competence to consent to medical treatment, rather

than research participation. The underlying concepts are the same, but the research area is governed primarily by federal regulations.

Terminology

It is important to distinguish between two often confused and interchangeably used terms: competence and capacity. Competence, a legal construct, refers to a court's determination of whether a patient possesses the requisite capacities to make a medical decision. Capacity, however, is assessed by medical or mental health professionals in the clinical setting (Berg et al. 2001). Decision-making capacity falls along a continuum; competence, however, is a binary category—a court must judge a person either competent or not. The two concepts are interrelated; judicial determinations of competence generally rest on the clinician's evaluations of capacity.

In practice, clinicians act as the “first line of defense” in determining whether a patient is capable of consenting to treatment. If a physician finds that a patient lacks capacity to make an informed choice, then he or she consults a surrogate decision-maker (often one or more family members). This approach renders the patient *de facto* incompetent: incompetent in fact, but not legally adjudicated as such. Courts, however, may be called upon to formally adjudicate competence in a variety of situations involving different kinds of patients, including adult patients with permanent impairments in capacity (e.g., developmental or psychiatric disabilities), when family members and/or surrogates cannot agree on the course of treatment, where specific legal liability concerns exist based on the treatment decision in question, or when a patient with uncertain capacity refuses a recommended treatment plan (Appelbaum 2010; Berg et al. 2001). Capacity determinations are made daily by health professionals. Often mental health professionals are called upon to provide more extensive evaluations, or to assist with a difficult determination. By contrast, court determinations of competence are relatively rare. Because a judicial determination can only be changed through another judicial hearing, formal competence proceedings should be used sparingly. In most cases informal determinations of incapacity will be sufficient and are preferable as they can more easily accommodate the normal fluctuations in patient decision-making abilities.

While courts can determine a person generally incompetent for all decisions and purposes (global incompetence), this is becoming less common. More often a court will rule a person incompetent for a specific decision or for limited purposes (specific incompetence) (Berg et al. 2001). For example, courts almost always distinguish a person's competence to make medical decisions from competence to make financial or other life decisions. A competence determination can even be specific to certain types of medical decisions, although this is more likely to occur via an informal capacity evaluation than through a formal competence adjudication. Thus, a patient may have the capacity to make a less complex treatment decision such as whether to take a daily aspirin, but not to make a more complex treatment decision such as whether to consent to open-heart surgery. The idea of different levels of competence required for different types of decisions seems intuitive, but is not well codified in law. We will return to this point later.

Presumption of Competence

Adults are presumed competent unless evidence indicates potential problems. Minors—a legal category that can vary according to state but usually refers to those under 16–18

years of age—are presumed incompetent, although there is increasing effort to include minors in medical decision-making (see discussion of minors below). The presumption of competence for adults remains even where a court previously deemed a person incompetent in another setting (Fisher 2009; Berg et al. 1996). Moreover, the presumption of competence is not automatically defeated with diagnosis of a mental illness or commitment, whether voluntary or involuntary, to a mental health facility.

As testament to the emphasis placed on the right to be presumed competent, several states have laws protecting the presumption in situations where people may be especially vulnerable (Fisher 2009). For example, Alaskan law states that even people with court-appointed guardians may not be presumed incompetent as a result of a guardianship, and further specifies that all rights not explicitly granted to the guardians remain with the individuals (Alaska 2012). California requires (1) that people retain their presumption of competence following treatment or evaluation for either mental illness or chronic alcoholism, and (2) that individuals be notified of their protected status upon leaving a mental health facility where services were sought (California 2012). Finally, Texas law specifically enumerates the rights of people with mental retardation, including the right to be presumed competent (Texas 2011).

Any limitation of decision-making authority (even requiring an evaluation of capacity before accepting a decision) restricts an individual's freedom. Because we want to be especially careful about imposing such limits in the absence of a clear indication of impairment, the law recognizes a general presumption in favor of competence. Just the act of questioning someone's capacity may limit their autonomy in some sense; a person whose capacity has been questioned is no longer able to make a decision without any interference until a determination has been made. We may accept this burdensome effect of questioning another's capacity because of the importance of assuring that certain decisions, such as those that deal with one's body and health care, are made by capable, and thus fully autonomous, patients.

But it is worth noting that not all decisions are of such import that we must ensure they are fully autonomous. We do not question an adult's freedom to make a multitude of choices throughout the day (what to wear, what to eat, where to go, what to buy, whom to marry, etc.). Nonetheless, many of these day-to-day decisions are likely made with varying levels of capacity (and therefore autonomy). For practical reasons we do not interfere with such decisions, even to assure ourselves the choices are completely autonomous and made by completely competent individuals. In this way, we also limit the extent to which we interfere with overall autonomy to make decisions free from the interference of others.

Elements of Capacity and Standards of Competence

As mentioned previously, competence standards should be based on those capacities necessary to make an autonomous decision. While there may be disagreement about the extent of capacity necessary in a specific context, there are some basic abilities that should be included in all situations. For example, someone who cannot communicate at all, or is generally unaware of their situation (e.g., someone who is unconscious) does not have the capacity to exercise any autonomy. In addition, someone who lacks the ability to understand the decision at hand, or information related to the decision, likely also lacks the capacity to make an autonomous decision. In fact, understanding is the most common capacity requirement. Beyond this, however, there is some debate.

Legal standards for competence vary by jurisdiction (Berg et al. 1996). Courts look to the relevant state law to determine which capacities are required for a ruling of competence, and evaluate medical findings and witness testimony accordingly. Although there is variation between jurisdictions, in general competence standards use some combination of four components: (1) the ability to communicate a choice; (2) the ability to understand relevant information; (3) the ability to appreciate the nature of the situation and its likely consequences; and (4) the ability to manipulate information rationally (Berg et al. 1996). There are a few outlier statutes that use vague standards such as “ability to make an intelligent choice”; ideally, however, the laws use language that can be more readily linked to specific capacities.

The first component, ability to communicate a choice, is the least stringent requirement. Clearly someone who cannot communicate a choice at all should not be considered competent. Patients who speak other languages, or who need to communicate through non-verbal means, however, do not lack the ability to communicate a choice. In contrast, a patient who can communicate but who cannot reach a decision, or who changes his mind so rapidly as to make it impossible to settle on one option, would fail this standard. This is a trickier situation than the person who simply fails to communicate at all. While the communication component often marks the lower threshold of capacity, it rarely stands alone in determining competence. It is a necessary, but not a sufficient, element. Thus, courts and legislatures usually apply the communication component in conjunction with one or more other components.

The second component, the ability to understand relevant information, is the most commonly used and most heavily weighted element of capacity. It requires that a patient understand specific information related to the decision at issue. Because of this, the informed consent disclosure itself is often used to test understanding. A patient may be provided the relevant information to make the decision and then asked whether she understands the key concepts and issues. Patients are not necessarily required to comprehend the situation as a whole, but rather the specific issues pertaining to informed consent disclosures. Scholars point out that this type of abstract understanding should be distinguished from appreciation, which is sometimes referred to as “deep understanding.”

This third component, the ability to appreciate the nature of the situation and its likely consequences, focuses on a patient’s ability to apply the abstractly understood information to his own situation. In some cases a patient may understand generally the procedure or diagnosis and thus meet the basic understanding component, but fail to appreciate how this information relates to her specific situation (i.e., fails to demonstrate appreciation or “deep understanding”). For example, a patient may understand that a positive antibody test means someone has contracted the human immunodeficiency virus (HIV), but later refuse to acknowledge she has HIV despite repeat positive test results from the patient’s blood samples. In such a case, the patient may be found incompetent because she failed to appreciate the nature of her specific situation or the future implications. Distinguishing between understanding and appreciation may be difficult in practice, and capacity evaluations may conflate the two concepts. But from an ethical perspective it is important to separate out the two. A failure of understanding may stem from a cognitive deficit, but in some cases can be remedied by focusing on the mechanism, timing, or amount of information disclosure. A failure of appreciation may stem from less easily addressed impairments or barriers, such as the inability or even refusal to accept longer-term consequences.

Several states appear to require both appreciation and understanding in their standards for competence. In Massachusetts, for example, the Supreme Judicial Court held a man incompetent when physicians diagnosed him with schizophrenia, but he denied he suffered from mental illness and accordingly refused to take antipsychotic medication (*In re Roe* 1992). In the case, the man *understood* the risks associated with taking the prescribed antipsychotic medicine, but, as the court stated, “he clearly [did] not *appreciate* the risks associated with refusing it.” In other words, the court deemed the man unable to appreciate the need to control this illness with antipsychotic medication. This case provides an example of how the distinct qualities of understanding and appreciation work in tandem to demonstrate competence. Using understanding alone, the state would have deemed this man competent because he understood the factual risks of taking the medicine.

Simply refusing treatment does not render a person incompetent. Indeed, the law allows competent people to make any decision, reasonable or not, when it comes to controlling their health care. In another Massachusetts case, the appellate court upheld a woman’s right to refuse amputation of her gangrenous leg (*Lane v. Candura* 1978). Because the woman appreciated both that her leg was infected with gangrene and that she would likely die without amputation, the court found the woman to be competent. As a competent patient, the woman was free to refuse even life-saving treatment.

By requiring appreciation, legislatures and courts recognize that delusional beliefs affect competence only if those delusions interfere with a patient’s ability to appreciate the nature of his or her own situation and likely consequences. But that nuanced recognition depends largely on the language contained in a state’s law and how state courts interpret that language. For example, in Vermont, the law states that “[i]n determining whether or not the person is competent to make a decision regarding the proposed treatment, the court shall consider whether the person is able to make a decision and appreciate the consequences of that decision” (Vermont 2012). So when a trial court deemed a man incompetent simply because he had delusions and other mental health symptoms, the Supreme Court of Vermont reversed and sent the case back for further review (*In re L.A.* 2006). Instead of merely listing the patient’s symptoms—which frequently occurs in cases where parties seek involuntary medication—the trial court needed to look further to determine if and how the patient’s symptoms affected his ability to make the decision in question and to appreciate the consequences of that decision.

The final component, the ability to manipulate information rationally, focuses on the patient’s ability to reason. Sometimes difficult to evaluate objectively or with quantitative measures, this criterion is sometimes excluded from states’ legal competence standards. There is also some concern that the component will be improperly applied to evaluate the rationality of the final decision, rather than the decision-making process. The requirement is not that a patient makes a correct, conventional, or even reasonable decision, but that he follows a rational process to arrive at the final decision (based on those factors which the patient himself finds to be most relevant). For example, someone who states that it is important to choose a treatment option that does not take him away from his small children for any period of time, but then chooses a surgical option which involves a considerable hospital stay instead of an outpatient medical option, without any explanation of why, may fail this component. The rational manipulation component, like the communication criterion, is not used as a standalone test for competence. Just as someone can communicate a choice without understanding or appreciation, a person can reason and manipulate facts without actually understanding

or appreciating them. Thus a patient who believes (based on lack of understanding) that sunlight will kill a staph infection may take reasonable steps to increase exposure to sunlight, and make medical (and other) decisions to facilitate that exposure.

Courts sometimes struggle with the application of the reasoning component. For example, California competence law includes two distinct elements: (1) the ability to understand and appreciate the consequences of decisions (and mental illness can only be considered if it significantly interferes with the patient's ability to do so); and (2) the ability to participate in a treatment decision through a rational thought process (*In re Conservatorship of Burton* 2009). These requirements were at odds in *Burton* because the patient understood and appreciated the consequences of going on a hunger and medication strike (which could be grounds for finding him competent under the first requirement) but based his decision on psychotic delusions (which could be grounds for finding him unable to participate in a rational decision-making process under the second requirement). The court resolved the conflict by holding that the second requirement, the ability to engage in a rational decision-making process, was meant to stand alone and thus superseded the language limiting consideration of psychotic symptoms. In the court's view, appreciating the consequences that could result from an irrationally reasoned decision does not render a patient competent. Thus, even though the patient argued that his delusion did not interfere with his ability to appreciate the consequences of his hunger strike, the court ruled the patient incompetent with regard to that decision because his delusions prevented him from participating in a rational decision-making process in the first place.

Perhaps most difficult from both the legal and ethical perspectives are the cases which are based on contested religious beliefs such as faith healing. Patients in these cases follow a rational decision-making process refusing medical care and seeking help from faith healers. While parents may not be allowed to rely on faith healing for their minor children, it is less clear whether adults should be allowed to rely on it for themselves. Faith healing is one of the more extreme situations, but these debates about allowing refusal of treatment also arise in other contexts such as those involving Scientologists and Jehovah's Witnesses.

Applying the Standards

Courts and legislatures employ various combinations of these four components in their legal competence standards. Although the requisite capacities differ by jurisdiction, the goal of these standards remains constant: to determine as accurately as possible who is capable of making autonomous medical decisions and who requires a surrogate decision-maker. There remain various questions related to the application of the standards, including the scope of information that should be used to demonstrate capacity and the means by which capacity should be tested.

First, if understanding is a necessary element of capacity, what information must be offered and understood in a specific context? There are two aspects of this inquiry—quantitative and qualitative. From a quantitative standpoint, should there be a threshold amount of information that must be understood for a patient to be considered competent? If so, would it be 50 percent of the information disclosed, 75 percent, 90 percent, or more? From a qualitative standpoint, are there specific facts that must be understood no matter how much other information is understood? For example, for a surgical procedure, should we require a full understanding of the risks and implications of general anesthesia (qualitative), regardless of whether the patient understands 95 percent of the

remaining overall information (quantitative)? Importantly, standards should not be set so high as to exclude the majority of the population from making their own decisions. That is to say, we should not require levels of autonomous decision-making that are beyond most people's capacity levels. Thus, some empirical work may be needed to understand the range of abilities in the general population.

There are few direct requirements regarding what specific information to put into an informed consent disclosure. A few hospitals provide checklist consent forms for physicians. Laws in some states require specific disclosures for certain procedures, although this is rare. For example, a handful of states define by statute specific information that must be disclosed related to breast cancer screening and treatment options. Rather than provide specific requirements, most states use general standards for disclosure, requiring at least that information which a "reasonable patient" would want to know, or that a "reasonable professional" would disclose. In practice, now, the two standards result in similar, if not identical, disclosures (i.e., most reasonable professionals disclose what reasonable patients would want to know). These standards, however, do not speak to the quantitative or qualitative questions raised above.

One approach to the quantitative question is to have a set standard for all decisions (e.g., everyone must understand 80 percent of the information disclosed), another is to allow a sliding scale based on the importance of the decision in question (e.g., 75 percent for simple decisions and 90 percent for complex ones). There are also suggestions that the issue is not complexity, but riskier decisions should require greater levels of capacity. Sliding scales are likely to be difficult to apply in practice. Moreover, it may prove hard to distinguish "simple" from "complex" decisions, or between levels of risk. The real concern is the consequence of a wrong determination of competence. We are often less concerned about a person who is incompetent consenting to a medically recommended treatment, than refusing such treatment. This is because we assume (rightly or wrongly) that the consequences of an incompetent consent are usually less momentous than an incompetent refusal; we may weigh beneficence in these situations more heavily than autonomy. But there are numerous medical decisions that fail to fall easily into a simple or complex category, and for which a medically "recommended" option may not be identified readily. And perhaps more importantly, beneficence is hard to separate from autonomy; one important point of respecting autonomy is to recognize that the patient is often a better judge of what treatments are in his or her benefit (since "benefit" is broader than simply medical benefit). The best approach may not be to use different standards for different types of decisions, but to allow these other factors to trigger more scrutiny of patient capacity. As noted previously, the default is a presumption of capacity. Even questioning a patient's capacity is an imposition on autonomy—better avoided if there is no reason to interfere. This is not to say that we should not be concerned with incompetent consents to treatment, but that we should consider a range of factors in deciding whether to examine capacity more closely. A refusal of treatment is one element (in the past, a refusal alone was often wrongly equated with incapacity). Failing to understand a crucial fact (the qualitative factor above) is another. A lower percentage of understanding (the quantitative factor above) is a third. Any or all of these elements may trigger additional evaluation of capacity by medical professionals, or weigh into a court's determination of competence. None should result in automatic determinations of incompetence.

Besides types of questions about applying the standards, there are also questions about how to engage in a capacity evaluation. Should a standardized capacity tool be used, or

should informal mechanisms be employed? As noted earlier, the best solution is to use the informed consent disclosure itself to test capacity, rather than an abstract capacity tool. We are concerned with the patient's ability to understand, appreciate, and rationally manipulate information related to the decision at hand, not necessarily whether they can remember a stream of numbers or be perfectly oriented to time or place. These latter tests may be good triggers for additional capacity evaluations, but should not be a sufficient basis for determining competence. In contrast, the MacArthur Competence Assessment Tool for Treatment (MacCAT-T)—the most widely used capacity assessment instrument—incorporates specific details of the patient's pending medical decision, thus making the assessment more akin to an informed consent disclosure than a separate screening test. The MacCAT-T uses a structured interview process, which can be administered in approximately 15–30 minutes (Dunn et al. 2006; Appelbaum 2007). It assesses communication, understanding, appreciation, and rational manipulation through a series of physician-facilitated questions. To help ensure accurate and reliable findings by clinicians, the MacCAT-T offers extensive training materials, including both a manual and video.

Surrogate Decision-Making

Unlike other exceptions to informed consent, a finding of incapacity or incompetence does not relieve the health care professional of disclosure obligations, nor does it avoid the need to identify a decision-maker with legal authority to make the treatment choice. This decision-maker is called a “surrogate,” and he or she is entitled to all informed consent information that would have been shared with the patient. There are different types of surrogates: guardians or conservators, who are legally designated through a judicial process; health care proxies, who are legally designated by the patient in a living will or health care power of attorney; and informal surrogates (family members or close friends) identified by health care professionals. Some states have statutes that specify a hierarchy of surrogate decision-makers to be consulted in cases of incapacity, and many health care institutions have policies that govern these interactions.

Surrogates make decisions based on one of two standards: substituted judgment or best interests. A substituted judgment standard is designed to have the surrogate determine what decision the patient would have made if he or she were competent. This is, of course, not an easy task and in many cases there may be limited evidence to help identify the appropriate choice. A best interests standard is used when there is little or no indication of the patient's preferences, or when the patient has never been competent. Decision-making for children and for developmentally disabled adults almost always uses a best interests standard. There are many complexities involved in the application of the standard and debates about the appropriate scope of surrogate decision-making, particularly in the end-of-life context. But these are beyond the scope of this chapter. One point that should be emphasized, however, is the importance of determining the capacity of the surrogate to make decisions. Like the patient, a surrogate must be competent and the norms described previously apply to the surrogate in cases of patient incapacity.

Capacity of Minors

The principle of respect for autonomy is less clearly applied to children than to adults (Goodlander and Berg 2011). Children develop the capacity for autonomous decision-making as they age, but there is wide variation among children even of the same age and

significant disagreement about how much children should be involved in medical decision-making. The developmental literature provides some rough guidelines. Children under the age of 7 rarely have the capacity to make autonomous decisions. Children between 7 and 13 are developing the relevant capacities for autonomous decision-making. Children over the age of 14 usually demonstrate the same decision-making capacities as young adults between the ages of 18 and 21. Even at these later ages there are some developmental limitations in decision-making. For example, most individuals in these age groups lack significant life experiences; there is also some empirical evidence that the ability to evaluate long-term risks (particularly risks of death) are impaired in teens and juveniles. Nonetheless, all states set the age of majority for decision-making between 16 and 18, and some allow certain decisions before this cut off. It is important to remember that the age of majority is just the age at which the presumption of competence shifts. Before that age, the presumption is that the individual does not have capacity, and after that age the individual is presumed to have capacity. Evidence in a particular case may show either presumption to be incorrect (Blustein et al. 1999).

Because capacities are developing and should be respected, and because autonomy is valued at all stages, minors should be involved in decision-making to the extent they are able. In some cases a minor's assent to treatment will be sought (instead of a formal informed consent). In other cases a minor will be given full decision-making authority. Informed consent laws in different states recognize legal status such as mature minors and emancipated minors, and also grant decisional authority over certain types of care, such as those relating to birth control, treatment of sexually transmitted infections, and mental health or substances abuse treatment (Goodlander and Berg 2011). These latter statutes are based mainly on public health rationales (e.g., it is better to allow access to the treatments in question regardless of autonomy), rather than a recognition of the minor's decision-making capacity. The laws in this area are silent on the question of whether to accept a minor's decision where there is clear evidence of incapacity either due to age or due to impairments. In other words, should the laws be viewed as simply shifting the presumption of capacity, as it is for adults, rather than granting legal authority regardless of capacity? For emancipated minors (i.e., a minor who has been determined by a court to meet specific statutory requirements for emancipation, based, for example, on marriage or participation in the armed forces), the legal presumption shifts, an emancipated minor who demonstrates impaired capacity should no more be permitted to make a decision than a legal adult who lacks capacity. The public health situations are trickier. The recognition of the public health goals may weigh in favor of a fairly low standard for capacity at least when making decisions in favor of treatment. Thus we may not scrutinize capacity for those minors who make decisions in favor of treatment to the same extent we do those who refuse recommended treatment. Essentially that is what the laws granting decisional authority are designed to do. As a practical matter, however, minors who chose not to seek treatment at all will not have their capacity evaluated. Those that do seek treatment may be more inclined to consent, so the distinction may have little impact. Moreover, there are various protections of minors' privacy and confidentiality that sometimes apply along with the grant of legal authority to consent. Thus, surrogate decision-making in these contexts may be more complex than the usual default of parental decision-making. This is an area that needs additional research.

Conclusion

Autonomy, particularly the right to make decisions as to one's body and health care, is deeply valued in American society. Promotion of autonomy requires that decisions be made by informed patients with sufficient decision-making capacity. Because the law protects a competent person's right to make a wide range of choices, it is important that competence determinations be based on more than just refusal to follow a physician's recommended treatment course. Instead, state legislatures (through statutes), courts (through competence hearings), and health care professionals (through clinical assessment of capacity) evaluate multiple aspects of decision-making ability. The abilities most often included in such evaluations include communication, understanding, appreciation, and rational manipulation. Adults are entitled to a strong and sometimes statutorily protected presumption of competence. Questions remain, however, regarding a number of points, including the best way to assess an individual's decision-making capacity; whether a threshold level of ability must be met on any aspect under evaluation (either qualitatively or quantitatively); and, in the case of minors, how to balance concerns about providing adequate protection, ensuring access to confidential treatment, and recognizing minors' varying development rates.

Fundamentally, informed consent represents a basic tension between our interests in promoting autonomy and protecting individuals from harm. Autonomy wins in most situations since the individual is generally best situated to determine their interests and thus maximize beneficence. But there are clearly cases in which patients are making choices that a treatment team and even family members believe are not in the patient's interest. In the absence of evidence of defects in capacity, voluntariness, or information disclosure, we may be limited in our legal ability to intervene. But ethics does not require we remain neutral in these situations; in certain cases it is appropriate to encourage patients to reconsider even fully autonomous decisions.

Related Topics

Chapter 16, "The Future of Informed Consent to Research: Reconceptualizing the Process," Paul Appelbaum
 Chapter 21, "Autonomy," Catriona Mackenzie
 Chapter 33, "Alzheimer's Disease: Quality of Life and the Goals of Care," Bruce Jennings

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