Decision-Making Competence and Respect for Patient Autonomy

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In informed consent of the kind widely advocated in contemporary Western medical ethics, a competent patient makes an informed and voluntary choice between accepting and rejecting a therapy proposed to her by her healthcare provider. The practice is justified in terms of respect for patient autonomy. The notion of autonomy referred to involves only procedural prerequisites. A patient is considered self-governing when she acts freely and with sufficient understanding in accordance with her self-chosen plan. On this understanding of autonomy, a self-governing patient thus need not hold certain substantive views as regards different treatments. Accordingly, accepting these points of departure, it would not be reasonable to define competence in a way that would entail that a patient can be competent only if she endorses such substantive views. Adopting an account of competence that excludes as incompetent treatment choices patients are autonomously willing to make would undermine the moral grounding of letting autonomous patients to make their own treatment choices.

I. Conceptions of Competence

According to what has been called the standard analysis of competence, a patient is competent to make a treatment choice when she has adequate capacity to understand, is sufficiently able to reason and deliberate, possesses a set of interests and concerns relevant to the decision she is to make, and is able to communicate the decision she arrives at (see, e.g., Appelbaum, 2007, p. 1836; Beauchamp & Childress, 2009, p. 114; Buchanan & Brock, 1989, p. 23; Wicclair, 1991, p. 91; and Gert, Culver & Clouser, 2006, pp. 220-221). Within this framework, three kinds of conception of competence have been distinguished.
According to the first approach, there is a certain minimum degree of ability to understand, deliberate, etc. a patient needs to have in order to be able to make a competent treatment choice (see, e.g., Buchanan & Brock, 1989, p. 49). According to the second approach, competence is relative to the outcome of a patient's decision-making process. For example, Gert, Culver, and Clouser (2006) maintain that a patient is competent when she is able to make a rational treatment choice. The main idea of the third main account of competence is that competence is relative to the risk the decision faced involves; low risk decisions presuppose less ability to understand, deliberate, etc. than high risk decisions do (see, e.g., Buchanan & Brock, 1989, p. 50-51, 53). Accordingly, it has been called the risk-related conception of competence. Most versions of these three approaches to understanding competence entail that the degree of decision-making ability competence presupposes varies from one type of decision to another. But when the question is about making the same type of decision, they would not appear to allow that the degree of decision-making ability competent decision-making requires can vary from one person to another. And in practice, competence assessment is often initiated only when a patient is willing to make a treatment choice that differs from the decision her healthcare providers would make in her case.

II. Competence and Autonomy
Let us first consider the view that a patient is competent when she has a certain minimum level of decision-making ability. Here the degree of decision-making ability a competent patient is to have should most credibly be determined on the basis of assessing how demanding the choice to be made is. If the choice is simple, the threshold is set low. If the choice is intricate, the threshold is set high. How complicated a given choice is taken to be depends on what considerations are deemed relevant to it. However, presently there is no account of relevance that would command the acceptance of all autonomous persons. The problem that entails here can be demonstrated in terms of the cases of two patients, Sarah and Jill. They are of the same age, have lived similar lives, and now suffer from the same disorder of
consciousness. There is a treatment with estimated 70% probability of restoring a degree of their mental abilities. Both Sarah and Jill have lost those capacities to an equal extent and, were their treatment successful, they would become equally capable of continuing their lives. As the therapy could not restore them to normal health, they would not be able to go on with their lives as they were before falling ill. But, were it successful and were they to continue to receive it, having the treatment would allow them to engage in several of the activities they find meaningful.

Though the cases of Sarah and Jill are very similar to each other, there is one important difference between them: Sarah cannot endure physical pain whereas Jill’s pain barrier is rather high. As it happens, the treatment that might help them is quite painful. Because they would both need continuous therapy, the hurt it would cause them would recur until the end of their lives. Since she would very much like to continue with even some of the pursuits she cares for and does not mind the pain the therapy would cause her, the decision whether or not to have the treatment is quite straightforward for Jill. But Sarah’s case is different. Though she too would very much like to continue with the pursuits she finds significant, in her case the painfulness of the therapy speaks against having it. Would the pain the treatment causes be worth enduring when the therapy cannot restore her to normal health? Though the 70% probability of success is not low, the treatment might still not work in her case, even if she received it repeatedly. Is that particular degree of risk worth taking when she could at best be able to engage in only some of the activities that have significance to her? Etc. Because of that one difference between their cases – the dissimilarity of their pain barriers, – making a competent decision about having the treatment requires significantly more mental ability from Sarah than it does from Jill. If a conception of competence does not account for that kind of variation in what is relevant to individual patients, employing it conflicts with paying due regard for patient autonomy whenever the understanding of relevance an individual patient autonomously accepts differs from the one the conception of competence involves.
Similar considerations apply in connection with the outcome standard of competence. For example, consider the view that competence means the ability to make a rational decision. As things are, there is no (sufficiently precise) account of rationality that would command the acceptance of all autonomous persons. Instead, there are several competing conceptions of what is rational and what is not. Let us assume that a conception of competence involves a notion of rationality which entails that refusing life-saving therapy is not rational in the case of a particular patient. Let us assume further that the patient herself autonomously rejects that conception of rationality and endorses a conception of rationality which entails that refusing the treatment is the rational thing for her to do. Accordingly, when she is faced with the choice of whether to accept or reject the therapy, she autonomously comes to the conclusion that she should not have it. Yet adopting the account of competence now in question, the patient will be deemed incompetent to decide about her own treatment just because she does not endorse a given controversial conception of rationality. That does not show sufficient respect for her autonomy.8

The risk-related conceptions of competence face a similar problem. Like rationality, the notion of risk is obscure and controversial. For the time being at least, there is no understanding of what is risky and what is not that would command the acceptance of all autonomous persons. Consider that the account of competence resorted to in assessing a patient’s decision-making ability involves a notion of risk the patient autonomously rejects. Then the patient can be deemed incompetent to decide about her own treatment merely because she autonomously accepts a different conception of risk than the one the conception of competence involves. Let us assume that the above patient faced with the choice between accepting and rejecting the life-saving therapy has been an exceptionally self-sufficient person whose main interest in life has been engagement in challenging intellectual pursuits. Though her having the treatment proposed to her could save her life, it would not cure her. She would remain dependent on hospital care and be unable to pursue the intellectual activities that alone have brought meaning to her life. She abhors that. Accordingly, dying would not deprive her of anything of significance to
her, but would instead relieve her from a condition she detests. Therefore, for this patient, the choice of whether or not to have the treatment would not be a high risk choice, but rather a low risk decision. It is quite certain that she dies unless she receives the treatment.

Consider another patient who faces a similar choice between accepting and rejecting life-saving therapy. This patient’s values are quite different from those of the (former) independent intellectual just described. This patient finds intellectual pursuits pretentious. His main interest in life has been shallow relationships with other people. Above all, he wants to live. Having the therapy proposed to him could allow him to have what he most wants. However, that is not certain; the treatment may also fail. Accordingly, for this patient, the choice between accepting and rejecting the (potentially) life-saving therapy would be a high risk choice. Again, employing a conception of competence that does not account for such variation in what different patients consider risky will be incompatible with respecting patient autonomy. Whenever the notion of risk the conception of competence involves differs from that of an autonomous patient, the patient’s self-government will not receive due regard.

Some versions of the risk-related conception of competence entail that high risk decisions presuppose more decision-making ability than low risk choices do only to the extent that the former are more complicated to make than the latter. Adopting that version of the risk-related standard of competence does not fare better than the one just briefly considered. How complicated a decision is considered to be depends on what is taken to be relevant to it. As already explained above, there is no conception of relevance that commands the acceptance of all autonomous persons. Accordingly, adopting a conception of relevance which differs from that of an autonomous patient is likely to lead into conflict with respecting her autonomy. Finally, proponents of the risk-related conceptions of competence assess competence on the basis of evaluating a patient’s decision-making process. That presupposes criteria by which the evaluation is done. Again, to the extent that the criteria used differs from the requirements an autonomous patient would set on an adequate decision-making process, for reasons similar to those
already explained above, the conception of competence is unable to pay due respect for the patient’s autonomy.

The above considerations suggest that the notion of competence should be defined in terms of the autonomous values and concerns of the individual patient whose competence is being assessed. In other words, what features of her situation and options a patient must be able to take into account in order to be able to make a competent choice and how should be determined on the basis of what the patient autonomously considers important. For example, to continue with one of the above cases, we should not require that to be competent to decide about her treatment Jill should be able to make complicated calculations as regards the painfulness of the therapy proposed to her. In her autonomous view, the discomfort the treatment causes is not a relevant factor. For Jill to be able to make a competent choice, it suffices that she comprehends the considerations that in the light of her autonomous values and concerns are relevant to it.

**III. Two Possible Objections**

Someone might object that the conception of competence proposed above is too demanding to be practically useful. For how, the criticism could proceed, could healthcare providers have such knowledge about their patients’ values that it presupposes persons making competence assessments to have? As acquiring the information about patients’ values can be impossible, the conclusion here would be, in practice it ought to suffice that healthcare providers secure that their patients have not misunderstood the nature of the treatments proposed to them.¹¹

When a healthcare provider is not well acquainted with his patient and there is reason to doubt that the patient herself is able to inform him about her autonomous values, the healthcare provider can benefit from collaborating with persons who have adequate knowledge of the patient’s autonomous values, such as members of the patient’s family. Of course, sometimes the close ones of a patient want to mislead a healthcare provider about the patient’s true wishes so that they could, say, gain access to money that would otherwise be spent to her treatment. And it may be possible that
unbeknownst to all a patient who has led an apparently normal life has made so many heteronomous choices that even his honest close ones are unable to provide reliable information about his autonomous values. However, such cases would seem to be the exception rather than the rule. And of course, accepting that patient autonomy is an important value in healthcare, the existence of such cases does not entail that it would be permissible for healthcare providers to ignore their patient’s self-government when the necessary knowledge is available.

It might now be objected that if a patient’s competence is assessed in terms of what her close ones believe to be her autonomous values, we end up considering a patient competent only if she decides in the way those others think she should decide. Therefore, as it would make a patient’s competence dependent on what others think she should do, the proposed approach to defining competence is after all rather a hidden form of surrogate decision-making than an account of competence that can pay sufficient respect for patient autonomy.

As in health care practice competence assessments are not made by patients themselves, whether a patient is deemed competent will depend on what others come to believe about her decision-making ability. In that sense all medical competence assessment is like surrogate decision-making whatever account of competence is adopted. But that similarity to surrogate decision-making does not mean that in competence assessment others make patients’ treatment choices on their behalf. Instead, the question is about evaluating patients’ ability to decide about their own treatment by themselves. According to the approach proposed above, if a patient is deemed competent, she is allowed to make her own treatment choice in accordance with her own autonomous plan. And, as already explained above, the account of competence proposed is more able to pay sufficient respect for patient autonomy than are the conceptions of competence that involve notions of relevance, rationality, risk, etc. that patients may autonomously reject. If the result of competence assessment is that a patient is not competent to decide about her treatment, resorting to an appropriate form of surrogate decision-making becomes necessary. But surrogate decision-making methods are to be
utilized only after a patient is deemed incompetent. Saying that competence assessment should refer to a patient’s autonomous values is not saying that competence assessment and surrogate decision-making are one and the same thing.

**IV. Conclusion**

In light of the above considerations, competence should be defined in terms of the autonomous values of the individual patient whose competence is being assessed. Besides differing from how competence has usually been understood in current medical ethics literature, this suggestion as to how competence should be conceived has an important practical implication. Insofar as the current varied methods of assessing patients’ competence to make treatment decisions (see, e.g., Welie, 2001; and Appelbaum, 2007) do not take into account individual patients’ own values and concerns, they ought to be complemented along the lines demonstrated above.

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**Notes**

1 For the sake of brevity, I speak of treatment choices only. However, the considerations I present apply, *mutatis mutandis*, in connection with decision-making about research participation too.

2 The plan here is not a blueprint to be slavishly obeyed, but rather an outlook on how one’s life should proceed, one that may be subject to even far-reaching revision over time. For discussion on the value of autonomy thus conceived see, e.g., Harris (2001), Haworth (1986), Kraut (2007), and Rachels & Ruddick (1989).

3 For clarification of what it in general means to have the kind of ability to understand, deliberate, etc. proponents of the different conceptions competence consider to be relevant in this context see, e.g., Beauchamp & Childress (2009) and Buchanan & Brock (1989).

4 All versions of the second type of account of competence do not require that a patient can be competent only if she actually makes a rational decision.

5 Similar considerations of risk could, however, also be applied in the case of the minimum standard of competence and at least some versions of the outcome standard of competence.

6 Some proponents of a risk-related conception of competence have proposed that besides focusing on how risky the decision to be made is a conception of competence should also attend to whether a patient’s decision-making process leads to a choice that promotes her own goals (Brock, 1991, p. 109). The resulting position would appear to be a kind of compromise between endorsing a notion of risk that may differ from the one the patient accepts and accounting for the patient’s own values. It is unclear how the compromise ought to be made, and the considerations below suggest that such settlement should be avoided.
As there would currently seem to be consensus that competence is to be assessed with respect to a specific treatment decision, I now put aside the view that there could be one competence level that applies in all cases irrespective of how demanding the choices to be made are.

Depending on the precise way in which they understand the nature of the mental abilities related to competence, those versions of this type of account of competence that do not require that a patient can be competent only if she actually makes a rational decision would not appear to be as threatened by this problem as those that count a patient competent only if she makes a rational decision.

It is sometimes maintained that in the medical ethical context risk must mean risk to the patient’s health. Yet this view too faces the problem just discussed above; why should risk be understood as health risk if the patient autonomously defines the notion differently?

It has also been maintained that, though more risky decisions do not require more ability to understand, deliberate, etc. than less risky decisions do, in the case of the former it is justified to require more evidence of competence than it is in the case of the latter (see, e.g., Cale, 1999, p. 148; DeMarco, 2002, p. 244; and Wicclair, 1999, p. 153). As it presupposes an account of competence, that position does not amount to a further variant of the risk-related standard of competence.

It has been maintained that the notion of competence is a legal concept and that judgments concerning patients’ competence, or (mental) capacity, to make treatment decisions should be left to courts. However, allowing only courts to determine whether a patient is competent would probably stop the functioning of both the judicial system and the practice of medicine. In any case, my focus in this article is on the question of how competence ought to be understood, not on who should judge whether a patient is competent to decide about her treatment.

As a result of confronting a serious illness a person can also change her values even significantly. Though the autonomy of such adaptations has been considered questionable, it has also been recently argued that adapting one’s preferences to one’s circumstances can sometimes rather be a sign of autonomy than of heteronomy (see, e.g., Baber 2007; and Bruckner 2009). Rhodes and Strain (2008) discuss possible ways of overcoming the problems that our tendency to misjudge how we would feel about undergoing different kinds of experiences cause to respecting patient autonomy. Examining the different ways in which our assessment of other persons,’ or of our own, autonomy can go astray is unfortunately beyond the limits of this work.

References


