

The Inadequacy of Incompetence

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IT IS COMMONLY HELD THAT THE COMPETENCE OF patients to make medical decisions is the principal concept for determining whether those decisions may be overruled. We disagree and argue that competence to make medical decisions is neither a necessary nor a sufficient condition for determining when it is morally justified to overrule patients' treatment refusals. It is not a necessary condition because it is morally justified to overrule some patients who are, on many standard definitions of "competence," entirely competent to refuse. It is not a sufficient condition because the fact that a patient is not competent to refuse does not by itself morally justify overruling his refusal.

The Logic of Competence

To discuss competence with precision one should focus on a person's competence to do a particular kind of action or make a particular kind of decision, rather than trying to characterize the person as a whole. This article is concerned with a person's competence to make a decision about medical treatment. However, even this is too wide a classifica-

tion, for a person may be competent to make one kind of medical decision and not another kind; for example, she may be competent to make the kinds of decisions that involve only immediate consequences, but not those involving long-term consequences. It is thus important to establish what counts as a *kind of decision* so that one may determine whether a person is competent to make that kind of decision.

On many standard accounts, including ours, *two decisions are of the same kind with regard to competence when a person who understands and appreciates the pertinent information relevant to deciding in one way—for example, consenting to a treatment—also understands and appreciates the pertinent information relevant to deciding in the other—refusing the very same treatment.* It should not be surprising, when we are discussing a person's competence to make a decision about his medical treatment, that if we regard him as competent to consent to a given medical treatment, then we must regard him as competent to refuse that very same treatment. One point of determining whether a person is competent to make a certain kind of decision about medical treatment is to allow a competent patient to make any decision he wants regarding that kind of treatment. (On rare occasions the courts have overridden the treatment refusals of competent patients when the interests of third persons, such as dependent children, are involved. We are concerned here with the more common issue of paternalistically overriding patients solely or principally for their own benefit.)

It is important to note, in talking about a person's competence to make a decision, that we are talking about the person, not about the decision. We may disagree with the decision, even regard it as seriously irrational, without negating the competence of the person to make it. Ideally, we should determine the person's competence prior to his making the decision, for the current legal doctrine is that a competent patient be allowed to make any decision he wants. In fact, however, certain decisions tend to make one challenge the competence of a patient, whereas other decisions do not. Nonetheless, if we are prepared to accept that a patient is competent to make a kind of decision—for example, he is competent to consent to a particular treatment in specific circumstances—then we must accept that he is competent to refuse the very same treatment in these same circumstances. In addition, if we treat a refusal as if it were made by a person incompetent to make that kind of decision, we must treat that person's consent in the same way. When dealing with competence to make a decision, the particular deci-

sion made should never be conclusive in determining competence, otherwise we are not really dealing with the person's competence, but with some feature of the decision itself, or what we term its rationality.

Although we appreciate the force of the principle that one ought never to overrule the treatment refusal of a competent adult, we think there are some very limited but important exceptions to this principle. Further, we hold that almost everyone, including doctors, lawyers, and judges, would agree with us about when it is justified to overrule the treatment refusal of a particular patient. However, the reluctance to challenge openly the absoluteness of the principle that a competent adult's refusal should never be overruled has obscured this agreement.

This reluctance to challenge openly the principle, together with at least tacit agreement that certain seriously irrational refusals should be overruled, has led to confusion and to a distortion of the concept of competence. This distortion was once implicit; recently, however, there have been two explicit attempts, which we shall examine, to revise the concept of competence in order to continue the legal fiction that no competent patient's refusal should ever be overruled. We believe that open recognition of the limited but important exceptions to the principle of never overruling a competent patient's refusal would better preserve the freedom of competent patients than the present hypocritical acceptance of the absoluteness of the principle.

The Definition of Competence

One plausible definition of competence is that a patient is competent to decide whether to consent to or refuse treatment if she adequately understands and appreciates the information given to her during a properly conducted consent process (Culver and Gert 1982). This definition of competence does not include within it any reference to whether the patient decided to consent or refuse, nor does it indicate whether the patient's consent or refusal seems, on either subjective or objective grounds, to be wise or foolish, rational or irrational, impulsive or deliberate. Competence to decide whether to consent or refuse is rather defined exclusively as an ability to carry out certain mental tasks: to understand the information relevant to making the decision; to appreciate how this information applies to oneself in one's current situation; and to realize that one is being asked to make a decision

about the treatment(s) being suggested. If these conditions are satisfied, a patient is fully competent to make the decision. If only some, or none, of these conditions are satisfied, then the patient is only partially competent, or is incompetent, to make the decision.

If a patient understands and appreciates the information but doesn't care to make a decision, that does not reflect on his competence to make it. There is no requirement that one *use* one's competence to make a particular decision. If a person is competent to make a kind of decision and demonstrates this competence, then he can go ahead and make his decision by flipping a coin without affecting the fact that he is competent. If one requires a patient to make use of his competence when making a decision, then one is no longer judging the competence of the person to decide, but the rationality of the decision made. This would subvert the point of the principle of never overriding the decisions of competent patients, which is to allow patients competent to make a given kind of decision to make any decision they wish to make.

Responding to Patients' Decisions

The concepts of competence and incompetence, by themselves, seem almost always to be sufficient to explain when it is morally justified to accept or not accept patients' *consents*. This is because the treatments that doctors propose are almost always ones that it is rational for patients to accept. Thus, patients' consents are almost always rational, and the only factor that needs to be taken into consideration is whether or not the patient is competent—whether she understands and appreciates what she has been told about the likely consequences of the options open to her.

When dealing with patients' refusals, the concepts of rationality and irrationality become more important because on rare occasions patients' refusals are seriously irrational. (The concept of irrationality is discussed further below.) When both consent and refusal are rational, then the concepts of competence and incompetence play the major role in deciding whether or not to accept the patient's decision. If the patient is competent to make that kind of decision and the refusal is rational, then the physician must abide by the refusal. However, even when the refusal is rational, if the patient is incompetent, then, just as with a rational consent, the refusal cannot simply be accepted as determining

what the physician should do. A proxy must be designated to make the decision. However, the proxy should be allowed to overrule the patient's decision only if it is clear that if the patient were competent to make that kind of decision, he would have consented to the treatment—in other words, that the patient prefers the outcomes associated with consent to the outcomes associated with refusal and refused only because he did not understand what the result of this decision would be. If it is unclear what the patient's choice would be, the refusal should hold.

If the refusal is mildly irrational, we think that the competence or incompetence of the patient determines the matter in the same way. A physician must abide by the even mildly irrational refusal of a patient competent to make that kind of decision. If a patient is incompetent to make that kind of decision, then a proxy should be designated. It should be determined if the patient refused only because he did not understand the consequences of his decision. Only if it is clear that the patient prefers the outcomes associated with consent to the outcomes associated with refusal should the proxy be allowed to override the patient's refusal. Further, only if it is clearly because of the patient's incompetence to make the kind of decision he made should anyone, including the patient's proxy, be allowed to overrule an incompetent patient's refusal. Thus, with both rational and mildly irrational refusals, it is the competence of the patient that should determine whether or not the physician should abide by the patient's refusal.

However, when the refusal is seriously irrational, as when the consequences are death or serious and permanent injury, the competence of the patient to make that kind of decision should play little if any role in determining whether the physician should abide by the refusal. No one has any doubt that if the patient is incompetent to make that kind of decision, then a seriously irrational refusal should not be accepted. We claim that a seriously irrational decision should be overruled regardless of whether or not the patient is competent. If the patient's refusal will result in his death or serious and permanent injury, and no one will benefit in any way, directly or indirectly, from this refusal, the refusal should be overruled. It is only a misguided adherence to the absolute principle that a competent patient's refusal should never be overruled that leads physicians, lawyers, and judges to claim that the patient who makes a seriously irrational decision is *ipso facto* not competent to make that kind of decision.

The following case illustrates this point:

Case #1. A man is admitted to a psychiatric inpatient unit because of his severely depressed state. He does not wish to be admitted but does not physically resist. Adequate dosages of several antidepressant medications have been given to him before admission; none has been helpful and he recently has refused to take any medication. He now states that he wants to die and he refuses all food and fluids, hoping to starve to death. The health-care team believes he should be given electroconvulsive therapy (ECT) but he refuses. Although severe depression is sometimes accompanied by delusions or other forms of cognitive impairment, this man appears to have none and seems to understand his situation quite well: he knows his doctors believe he has a probably reversible illness and that they believe ECT would be an effective treatment. He also understands that his refusal of food and fluids will lead eventually to his death. He states that he once enjoyed life but now is so depressed that he does not want to be "cured" but wishes to die. His wife and children believe he should have ECT and begin the process of attempting to obtain guardianship through a probate court. In the meantime the patient becomes weaker and weaker, and the treatment team fears that his worsening state of dehydration may precipitate a serious cardiac dysrhythmia [he has a history of heart disease]. The patient's attending physician believes it would be prudent to administer IV fluids while awaiting the court decision about guardianship. The patient refuses permission for an IV line to be inserted. The physician tells the patient that for the patient's own protection the IV line must be inserted, and that he will be physically restrained if he does not cooperate. The patient does not physically resist the line's insertion.

The physician's decision to overrule the patient's refusal is justified, but not because of the patient's incompetence. The patient, as described, is fully competent on the definition given above: he understands the probable harms and benefits associated with treatment versus nontreatment; he appreciates how he will be affected by the consequences of the various different decisions he might make; and he is aware that he is making a decision that involves these consequences. Further, if he had decided to consent to treatment, there would have been no questioning of his competence to decide about treatment. Yet we believe there would be a nearly universal moral consensus that it is morally justified to overrule his refusal and to force treatment upon him.

This shows that there are at least some exceptions to the principle

that the refusal of treatment by competent patients should never be overruled. *It is in those cases where the overruling of treatment refusals is morally justified, but where consent would be correctly accepted as valid with no questioning of the patient's competence, that it becomes clear that it is the seriousness of the irrationality of the patient's decision, not the patient's degree of competence, that determines when that overruling is morally justified.* These cases make it clear because it becomes obvious that it is the decision itself which is being challenged, not the competence of the patient to make it. For if the patient had made a different decision—to consent—his competence to make that kind of decision would not have been questioned.

That it is the serious irrationality of the above patient's decision, not his lack of competence, that justifies overruling his refusal is shown by supposing that he changes his mind at a critical point in the case: he feels slightly less hopeless on the day that his physician wants to start the IV line and agrees both to the IV and to the administration of ECT. He knows no new facts, his intellectual abilities are unchanged, but his mood has slightly changed and he now consents to treatment. We believe that not only would the doctors proceed with treatment, but the patient's competence to decide about his treatment would not be questioned. Suppose that once again, however, just as the IV is about to be inserted, this ambivalent man experiences another change of mood, and repeats his refusal.

His physicians would once again, appropriately, overrule his refusal. What justifies overruling his refusal is that it is seriously irrational or, as is sometimes actually said, that it creates a dangerous or an emergency situation. However expressed, the crucial fact is that not overruling will lead to serious and permanent harm to the patient with no compensating benefit for anyone. If the doctors try to justify overruling by claiming that the patient is once again incompetent to make a decision concerning his treatment, they would have to admit that nothing about the patient's competence to decide, as the doctors themselves would probably define it, has changed. What can this patient do to demonstrate his competence and still make this irrational decision? If there is nothing he can do to demonstrate his competence while making a seriously irrational decision, this shows that the irrationality of his decision, and not his incompetence, is actually being used to justify overruling his refusal.

We have used an example of a depressed patient because there is

quite frequently a problem about whether or not to overrule depressed patients' treatment refusals. Some patients who are severely depressed, it is true, are incompetent, because severe depression can be accompanied by mental confusion or by delusions that interfere with their ability to understand and appreciate the information relevant to making a treatment decision. For example, a patient might believe he was being punished by Satan for his past wrongdoing, and that Satan would not allow any of the treatments to work because of the patient's extreme blameworthiness. However, depression, even severe depression, need not be accompanied by cognitive distortions. A patient may understand and appreciate all the salient facts about his condition, including what he is told about the treatment options confronting him, and still suffer from a profoundly depressed mood.

Another kind of case that shows the inadequacy of solely relying on incompetence to justify the overruling of patients' refusals is that of a patient who refuses because he fears a specific treatment. Imagine a case (Case #2) where a depressed patient's refusal is based solely on a fear of electroconvulsive therapy that the patient realizes is contrary to all that he himself knows about the procedure. He knows that he is seriously depressed and that pharmacological treatments have failed. He acknowledges that ECT would probably (a 60 to 70 percent chance or more) cure his depression. He acknowledges that the risks of ECT are very slight for him, and also acknowledges that whatever slight risks there are, they are much less than the risks associated with not treating his serious depression: about a 20 to 30 percent risk that he will die. He wants to live, he wants to be cured of his depression, and he knows that ECT will almost certainly cure him. Even though he knows all of the above, however, he dreads ECT and cannot bring himself to sign the required consent. Fear alone makes him refuse. His intellectual capacities are unaffected: he knows all the important facts that his doctors know about his situation; he himself acknowledges the "stupidity" of his fear and the pointlessness of letting it ruin, indeed, possibly take away his life. On most accounts of competence he would be acknowledged as competent. Following the principle of never overruling a competent patient's refusal, this patient might have to be allowed to die, a result almost no one would countenance. Thus, a patient's competence is not sufficient grounds for abiding by a patient's refusal when that refusal is based on a seriously irrational fear.

One area of the law explicitly acknowledges that the competence of

a patient has no bearing on whether or not to honor his refusal of treatment. Essentially no state statute (except Utah's) dealing with involuntary commitment specifies anything about the competence of the person to decide whether or not to be hospitalized. The statutes specify as commitment criteria only whether the person is suffering from a mental disorder and whether he presents a serious and immediate danger to himself or to others. Thus, the statutes are concerned with whether the person is going to act in a seriously irrational way such that he is likely to cause himself (or others) death or serious and permanent injury. Competence is not mentioned. It is generally considered morally justified, we think correctly, to hospitalize, temporarily and involuntarily, a person to prevent his causing himself death or serious injury when this would be an irrational act. However, even in this kind of case, there is usually no explicit talk of an irrational decision; rather, the situation is claimed to be an emergency situation or the patient is said to pose a danger to himself. Most states that have addressed the issue consider involuntary hospitalization and forced medication to be different matters, and committed patients cannot automatically be forcibly medicated. However, either action can represent a serious example of paternalistic behavior. Indeed, in particular cases, commitment may be anticipated to inflict more serious harm on a patient than would forced medication; thus the law seems internally inconsistent. However, the commitment laws, by focusing on dangerousness and not incompetence, seem to accord more with moral consensus and with actual practice.

Taking More than Competence into Account

Most definitions of competence restrict themselves to a patient's ability to carry out a set of mental operations, that is, to understand and to appreciate the consequences of different treatment decisions. These definitions say nothing about the content of the patient's decision, except to specify that it is a kind of decision the person has the competence to make. Competence is independent of the seriousness of the malady from which the patient suffers, or the seriousness of the harm the patient is likely to suffer if she does or does not consent to the suggested treatment. Yet if we consider what factors could justify forcing

treatment on a person, it is just these factors, particularly the latter, that are the most important.

Overruling a patient's irrational refusal of treatment in order to prevent her death or serious injury is the paradigmatic case of justified paternalistic behavior. Any adequate theory of the moral justification of paternalistic behavior must take into account the amount of harm the paternalistic action is intended to prevent or eliminate. Yet no definition of competence that, appropriately, focuses only on the intellectual ability of a person to make a kind of decision, not on the results of the particular decision, can contain any reference to such matters. Thus, more than the concept of competence is needed to explain and justify overruling some treatment refusals.

Part of what is needed is some reference to the seriousness of the harms or evils that the patient will suffer. In Case #1, it is clearly the fact that the patient will die if not treated that leads his doctors to override his refusal. If his refusal were to result in much less serious harms, overriding his refusal would not be morally justified. Also, it is important that there is no reason for the patient to suffer this serious harm. The patient is not suffering from some painful terminal illness so that death will come as a blessed relief; rather, treatment will almost certainly restore him to a more enjoyable life. What justifies overruling the patient is that his refusal will lead to his death without him or anyone else benefitting in any way.

Almost everyone who writes about overruling the refusal of patients agrees on the substantive point that if overruling is justified, what justifies it is the seriousness of the pointless harms that overruling will prevent. Some proposals, which we shall consider, try to do this by enlarging the concept of competence to include these matters. Our own preference is to use the concepts of rationality and irrationality, because these concepts, properly understood, are primarily concerned with the avoidance of suffering unnecessary harms. However, others have used such concepts as "dangerousness" or "emergency situation" to supplement the concept of competence when deciding at what point to overrule a patient's refusal. We prefer to use the concept of irrationality because it incorporates all of the relevant features that we and others actually use in determining the justifiability of overruling a patient's refusal. We should note that it is possible to accept our argument up to this point without agreeing that irrationality should be the additional necessary concept; however, it seems impossible to accept our argument

to this point without agreeing that the concepts of competence and incompetence, as ordinarily understood, are inadequate to explain or justify many cases of overruling patients' treatment refusals.

Appelbaum and Grisso (1988) have recently suggested that four legal standards of competence may be discerned in judicial findings and legal commentary: (1) whether patients communicate a choice; (2) whether patients understand the relevant information pertinent to a choice; (3) whether patients appreciate the situation they are in and thus the likely consequences of a choice; and (4) whether patients manipulate information rationally. Their fourth standard refers not to whether the patient's actual decision is "rational" in the sense that we use that concept: they are explicitly clear (p. 1636) that the patient's actual decision does not enter into the determination of competence. Rather, rational manipulation "involves the ability to reach conclusions that are logically consistent with starting premises" (p. 1636). We take these standards to be generally consistent with our own approach, especially insofar as they exclude the patient's actual treatment choice from the determination of competence. Our Case #1 would clearly be competent on the first three standards and also on the fourth, in that the patient's refusal of IV fluids is a "conclusion" logically consistent with his "starting premise" that he wished to die. It is the rationality of this desire to die, rather than his ensuing cognitive operations, that primarily determines whether it is morally justified to overrule his refusal.

Irrational Treatment Decisions

There is general agreement that "competence" and "incompetence" refer to a patient's ability or lack of ability to make a given kind of treatment decision. There may be some disagreement about how to specify the kind of decision, but there is no disagreement that in talking about competence and incompetence we are talking about the patient, not about the decision that she makes. When talking about the rationality or irrationality of the decision that is made, we need not be referring to any characteristic of the person making it. A patient's competence to make a given kind of decision about medical treatment can be determined during the consent process, without knowing yet what the patient will decide. The rationality or irrationality of the decision can be determined only after the decision is made. If the refusal of treatment

will lead to death or serious and permanent injury and no one, including the patient herself, will avoid a compensating harm or gain a compensating benefit, then the refusal is irrational.

A simple but imprecise way of defining an irrational decision or action is that it involves hurting oneself pointlessly. Usually, these kinds of decisions are made by people incompetent to make that kind of decision; however, as we have shown, a competent person may sometimes make an irrational decision. It is useful to define an irrational decision in more precise language. *A decision or action is irrational if the person making it knows (justifiably believes) or should know that its foreseeable results are that she will suffer any of the items on the following list: death, pain (either physical or mental), disabilities (physical, mental, or volitional), or loss of freedom, or loss of pleasure or be at increased risk of suffering any of these, and she has no adequate reason for her action or decision. All other decisions or actions count as rational* (Gert 1988). A decision that has no foreseeable harmful results for a person is rational even though she has no reason for it, and one that has foreseeable harmful results is rational if she has an adequate reason. This means that when there are no foreseeable harms, such as death or pain, no matter which alternative one chooses, each one of a set of incompatible courses of action may count as rational. Even when the foreseeable results are harmful, several incompatible actions or decisions may be rational, for there may be comparable harms for all of the alternatives.

A reason for acting or deciding is a conscious belief that one's decision or action will help oneself, or someone else, avoid or relieve some harm or gain some good (Culver and Gert 1982, 37). Patients almost always make treatment decisions in order to avoid or ameliorate a harm rather than to gain a good, so goods do not play a frequent role in classifying patients' treatment decisions. Beliefs that a treatment will benefit one by lessening a disability, eliminating a pain, or reducing the risk of death are all reasons for having the treatment. Thus, if I believe that by enduring some pain (for example, by having a carotid arteriogram, I decrease my risk of suffering some other evil such as death or serious disability from a stroke), then that belief counts as a reason for enduring the pain. However, one can also have a reason for performing an action that would not be irrational even if one did not have a reason; for example, one can have a reason for taking a walk.

Although there can be reasons for any kind of action, we talk of *adequate reasons* only when the action contemplated would be irrational

if one had no reason for doing it. A reason is an adequate reason when the harms avoided (or the goods gained) by suffering the harms of a contemplated act compensate for the harms caused by that act. Thus, the adequacy of a reason depends not only on the nature of the reason itself, but also on what it is a reason for. Consider a ridiculous example: having a leg amputated to eliminate the mild pain caused by a plantar wart. Believing that the amputation will eliminate the wart pain counts as a reason, but it is not an adequate one because no person deciding rationally believes that the harm incurred by losing a leg is compensated for by the elimination of the mild pain from a wart. Therefore, the decision to have the leg amputated would be irrational. However, the belief that the amputation might stop the spread of an osteogenic sarcoma in the tibia would count as an adequate reason, and having the leg amputated would therefore be a rational treatment decision. Thus the adequacy of a reason, and hence the rationality of a decision, depend on comparing the evils involved in two (or more) courses of action.

Not everyone may agree about what constitutes an adequate reason for refusing a particular treatment. Indeed, it is this disagreement about the adequacy of a reason, and hence about the rationality of a refusal, that is one of the primary motivations for trying to deal with the question of patient refusal solely in terms of competency. Some doctors seem to hold that there is no adequate reason for refusing a life-saving treatment if the patient will have, with treatment, any significant amount of conscious life. Most people do not agree with this view. We share the general view that there is no single preferred ranking of evils; rather, any reason that any significant group of competent people regard as adequate, is adequate. In our experience, theoretical disagreements about the adequacy of a reason, and hence about the rationality of a decision, do not usually enter into real cases of problematic treatment refusals. There is usually no doubt among all observers that the person has no reason at all, let alone an adequate reason, for refusing a treatment that is necessary to prevent his suffering a serious evil. In fact, it is the lack of any reason that is sometimes cited in claiming that the person is incompetent to make a decision to refuse.

It is principally the seriousness of the irrationality of a patient's treatment refusal that accounts for whether or not it is morally justified to force treatment upon him. Forced treatment is never justified if a competent patient's refusal is rational. In fact, it is usually not justified

to force treatment on competent patients even in the case of irrational refusals; that the refusal is irrational is a necessary but not a sufficient condition for forced treatment. The refusal must be so seriously irrational that even adding in the harm of forced treatment, it would still be irrational not to have the treatment. The only cases that meet this condition are those in which the patient faces death or serious and permanent physical or mental disability without treatment. It is the irrationality of the refusal that is the central element in justifying the overriding of treatment refusals. We have described at length elsewhere the criteria for morally justified paternalistic actions (Culver and Gert 1982, 143).

If a patient is incompetent to make a particular kind of treatment decision, then matters are somewhat more complex. However, even in these cases it is the degree of irrationality that is most important. Although one cannot simply accept a treatment refusal by a patient incompetent to make that kind of decision, one should never overrule a rational or even a mildly irrational decision, unless it is clear that the patient made the decision because of her incompetence. Thus, incompetence is sometimes relevant in determining whether or not to overrule patients' treatment refusals. Incompetence, however, is usually not sufficient to determine when a treatment decision should be overruled; usually it is the seriousness of the irrationality of the decision that is crucial. Irrationality is a concept independent of incompetence, and incompetence cannot do the conceptual work of irrationality. However, these two concepts together do seem to explain when we should accept patients' consents and when we should overrule their refusals. Competence is most important for accepting consents; irrationality, most important for overruling refusals.

An Alternative Approach to Evaluating Competence

Two recent attempts to define "competence" have been made by Drane (1985), and by Buchanan and Brock (1986, 1989). Their approaches are similar to that suggested earlier in an article by Roth, Meisel, and Lidz (1977). These theorists all suggest that "competence" be defined differently in different clinical situations: that a more exacting definition be applied in situations where the outcome of the decision

is more "serious" or "dangerous" for the patient, while a less stringent, more easily satisfied definition be employed in situations where the patient's life will be less affected by his decision to consent or refuse. In his sliding-scale model for competency, Drane (1985, 19) suggests three different levels of the seriousness of medical situations, and three corresponding standards for determining whether a patient at a given level is or is not competent:

Drane's Sliding-scale Model for Competency

LEVEL ONE. *Medical situation:* Treatment not dangerous; high benefit, low risk; limited treatment alternatives.

Competency standard: Patient must be "aware" of his medical situation and assent to treatment (i.e., say "yes," but need pass no test of understanding).

LEVEL TWO. *Medical situation:* Diagnosis doubtful; or diagnosis certain but treatment somewhat dangerous or possibly ineffective; or if there are alternative treatments; or if no treatment at all is an alternative.

Competency standard: Patient must understand the risks and outcomes of the different options, and be able to make a decision based on this understanding.

LEVEL THREE. *Medical situation:* Patient's decision is "dangerous"; it runs "counter to both professional and public rationality"; it is "irrational and life-threatening."

Competency standard: Patient "must be able to give reasons for the decision which show that he has thought through the medical issues and related this information to his personal values. The patient's personal reasons need not be scientific or publicly accepted, but neither can they be purely private or idiosyncratic."

It is important to see that Drane's sliding-scale model of competency is not a scale of competency at all, at least as that term is ordinarily used. It is rather a scale of when it is or is not justified to abide by a patient's decision to consent or refuse. In fact, it does not treat consent and refusal similarly even when they are the very same kind of decision with regard to competence, if consent is rational and refusal irrational. Drane's scale thoroughly conflates the competence of the patient with the rationality of her decision. In levels one and two, competence is defined according to a patient's partial or full understanding of relevant

information; in level three, the focus abruptly switches from the understanding of information to the making of what Drane calls a rational decision: one "based on relevant implications including articulated beliefs and values."

We agree with Drane that, when considering whether it is justified to abide by the patient's decision, it is necessary to consider both a patient's competence to make a treatment decision and the rationality of the decision that is made. However, we see no advantage to lumping these very different concepts under the name of just one of them. Consider a patient who is transiently depressed and wishes to die. He refuses all medical treatment of any kind. He is himself a doctor and understands the probable harms and benefits associated with all treatment alternatives as well as do the doctors who care for him. His doctors recommend treatment in a Drane level-two situation: a somewhat disabling but not life-threatening condition for which treatment is probably effective. Thus he is, on both Drane's and our account, fully competent. He refuses; he is defined as competent on the basis of his cognitive abilities and his refusal is honored; if he had consented, his consent would also have been honored. This is competence, properly understood, determined by the ability of the patient to understand and appreciate all of the relevant information, but independent of the actual decision the patient makes.

However, the nature of his condition worsens. It is now life threatening and the treatment, although probably not curative, may now be life saving. We now have a very strange state of affairs. If the patient consents to treatment we are in a Drane level-one situation, in which the patient need only have minimal understanding of his situation. However, if the patient refuses, it is now a Drane level-three situation. The patient must now not only fully understand and appreciate all the risks and benefits of the alternative courses of action, but he must also give articulated beliefs and values that are personally plausible as reasons for refusing. If he offers no reasons or only "private" and "idiosyncratic reasons," while still understanding and appreciating the situation as well as his doctors, and if he continues to refuse, Drane would now call the patient incompetent. Presumably, this would justify overruling the patient's refusal.

Thus the competence of the patient would change solely because of the actual decision he makes. Nothing about the patient's mental abilities would be changed. Suppose a patient refuses in what starts as a

Drane level-two situation: he can go from being competent to incompetent simply because the seriousness of his illness changes, even though there has been no change in his understanding, his reasons for refusing, his motives, his beliefs, or his intentions. Thus, whether a patient is or is not labeled as "competent" in this situation need depend on nothing about him as a person, nor on the difficulty or complexity of the decision he is called upon to make, but solely on the severity of the evils he may suffer. This changes competence from an attribute of persons, determined by their ability to make a kind of decision, to something that is jointly determined by persons' mental abilities and the severity of evils they will suffer if not treated.

Consider another result of Drane's model of competency. Two expert doctors examine a patient who manifests a puzzling array of symptoms. They disagree about the patient's condition: one believes it is a Drane level-two situation, the other believes it is a level-three situation. Both doctors believe the patient should undergo further diagnostic testing. The patient, who understands and appreciates the information the doctors have given him, including the fact that they disagree about the import of his symptoms, refuses further testing. The only reason he will give is that he is in no pain and simply prefers to wait until the nature of his condition becomes clearer on its own.

The first doctor, who does not believe the patient is in any particular danger if left untreated, claims the patient is competent to refuse. This level-two patient has, referring to Drane's model, made a decision based on his (correct) understanding of what he has been told. The second doctor, however, believes it is dangerous for the patient not to undergo immediate further testing; he does not believe this level-three patient's reasons for refusing are adequate, according to Drane's model. He therefore claims the patient is not competent to refuse. Thus, the two doctors disagree about the patient's competence. Their disagreement turns not on a difference of opinion about what they observe: they agree totally on the patient's signs, symptoms, and on their understanding of the reason the patient gives for not proceeding. Their disagreement turns rather on the different inferences they make about the signs and symptoms they see. Thus, whether this patient is regarded as competent depends not on an attribute of the patient, but on a professional disagreement about the meaning of a set of signs and symptoms. Yet if "competence" is an attribute of persons, which most believe to be the case, then changes in competence should covary with

changes in the person, not with theoretical disagreements between two physicians.

Although Drane's combining the two independent concepts of competence and rationality into one scale and then determining competence in part by the rationality of a patient's decision may reflect actual medical and legal practice, we believe it should be rejected. Drane can no longer discuss competence to make a decision about whether to consent to or refuse treatment because the criteria for competence may change depending upon whether one consents or refuses. Thus, in a particular situation, one can be competent to make a decision to consent, but at the very same time not be competent to make a decision to refuse. This conclusion vitiates the original goal of letting a competent patient decide whatever he wants, however, and results in a mere verbal adherence to the absolute principle that a competent patient's refusal should never be overruled.

Buchanan and Brock's Shifting Definition of Competence

Buchanan and Brock (1986, 1989) present a more detailed defense of essentially the same position: that the definition of competence depends on the rationality or irrationality of the patient's decision. If the "net balance [of other's (sic) risk/benefit assessment of that choice is] substantially better than for possible alternatives," only a low or minimal level of decision-making competence is required. If the "net balance [is] substantially worse than for another alternative or alternatives," a high or maximal level of decision-making competence is required (1989, 53). They realize that "[t]here is an important implication of this view that the standard of competence ought to vary in part with the expected harms or benefits to the patient of acting in accordance with the patient's choice—namely, that just because a patient is competent to consent to a treatment, it does *not* follow that the patient is competent to refuse it, and vice versa. For example, consent to a low-risk life-saving procedure by an otherwise healthy individual should require a minimal level of competence, but refusal of that same procedure by such an individual should require the highest level of competence" (1989, 51–52).

Buchanan and Brock recognize that this is a surprising conclusion, and one that needs a great deal of support, for it goes against what

they themselves see as the function of deciding that someone is competent. They say that "function is, first and foremost, to sort persons into two classes: (1) those whose voluntary decisions (about their health care, financial affairs, and so on) must be respected by others and accepted as binding, and (2) those whose decisions, even if uncoerced, will be set aside and for whom others will act as surrogate decision makers" (1989, 27). They clearly recognize that competence is decision relative, and the above quotation is to be understood in this way. They explicitly state: "Persons are judged, both in the law and more informally in health care settings, to be either competent or incompetent to make a particular decision. . . . Competence, then, is in this sense, a threshold concept, not a comparative one" (1989, 27). We agree completely with what they say here, but do not see how it can be taken as compatible with their claim that a person can be competent to consent to a given treatment, but not competent to refuse the very same treatment.

Buchanan and Brock specifically state: "The central purpose of assessing competence is to determine whether a patient retains the right to accept or refuse a particular medical procedure, or whether that right should be transferred to a surrogate" (1989, 28). This means they acknowledge that all and only competent patients have "the right to consent or refuse." However, if one employs their shifting definition of competence, then a patient in a situation where consent would be rational and refusal seriously irrational could *never* be said to be competent. This is because in such a situation a patient could never be allowed to refuse; if he did, he would become by their definition incompetent, which would then permit forced treatment to be carried out. Thus, because in such a situation the patient does not "retain the right to accept or refuse a particular medical procedure," *there is no way the patient could be regarded as competent before choosing.*

How could Buchanan and Brock have put forward a position entailing that persons in certain situations could never be regarded as competent? We believe it is partly due to their attempt to make the concept of competence perform too many functions. They not only want it to perform the function of "respecting the patient's self-determination," but also that of "promoting and protecting the patient's well-being" (1989, 29). Thus, they are forced into a definition of competence that is dependent on characteristics of both the patient and the patient's situation. We do not in any way think that the value of promoting and

protecting the patient's well-being is unimportant, or even less important than respecting the patient's self-determination; we think it is a mistake, however, to hold that both of these values are the concern of competence.

As Buchanan and Brock themselves explicitly state, the first function of competence is to protect a patient's self-determination. We think that this is its only function, and that their attempt to give it the function of promoting and protecting the patient's well-being is due to their uncritical acceptance of the absolutist view that no competent patient should ever have his decision overruled. If one wants to maintain this view, without requiring incredibly high standards of competence for consenting to safe and effective treatments, then it is necessary to hold that there are different levels of competence. Requiring different levels of competence for consent and refusal to the very same treatment allows one to hold that a competent patient's refusal should never be overruled, while at the same time not allowing a patient to make an irrational decision that everyone believes it is justified to overrule. Like Drane, Buchanan and Brock incorporate the concept of a rational decision into the concept of competence. This allows them to maintain the legal fiction that competent patients are never overruled; the reality is that they are calling any patient incompetent who makes a decision they believe it is justified to overrule.

Buchanan and Brock realize that "[t]here is no uniquely 'correct' answer to the relative weight that should be assigned to these two values [protecting well-being and respecting self-determination], and in any event it is simply a fact that different persons do assign them significantly different weight" (1989, 41). They use this fact to account for disagreement concerning the competence of a patient. We think this fact about disagreement explains why there is no uniquely correct answer about when one should overrule the irrational decision of a competent patient. We believe it is a mistake to distort the concept of competence by incorporating into it the function of protecting the patient's well-being.

It may be that Buchanan and Brock were misled by the increasing confusion that surrounds the concept of competence. Buchanan and Brock claim that "no single standard of competence . . . can be adequate for all decisions" (1989, 51). However, although all of us agree that competence is decision relative, Buchanan and Brock claim that this requires a different standard of competence for different decisions.

However, they do not show that the standard of understanding and appreciating is not adequate for all of these different kinds of decisions. What they do show is that if decisions have serious and dangerous consequences, then we are justified in overruling more easily than when the consequences are less serious.

Buchanan and Brock admit that “an adequate competency standard focuses on the patient’s understanding and reasoning, rather than upon the particular decision that issues from them” (1983, 33). However, their proposal does not do this at all. On their account, understanding and reasoning that are adequate to show competence to make a particular decision of a given kind, as in consent to treatment A, are not adequate to make a different particular decision of the very same kind — refusal of treatment A. One reason that Buchanan and Brock may not see this inconsistency is that they may not be completely clear about what is meant by saying that competence is decision relative. It is true that decisions can vary greatly in their information requirements, and in the cognitive skills needed to draw inferences about relevant consequences. Competence being decision relative in this way does not introduce any problems at all for an understand-and-appreciate account of competence. It is still true that if a person is competent to make a given kind of decision, that competence does not change with the decision made: if a patient is competent to consent, she is competent to refuse and vice versa.

However, if one adds, as Buchanan and Brock do, that competence is also decision relative depending on “the magnitude of risk involved” (1989, 64) then there are real problems. The risks involved in consenting not only may be but usually are quite different from those involved in refusing the same treatment. Hence, if competence is decision relative in this way, then one can no longer talk about the competence to make a given kind of decision where different particular decisions have different risks involved.

We can sympathize with the problem that both Drane and Buchanan and Brock are trying to solve: how to maintain respect for patient self-determination and still protect a patient from the serious harms that would result from a seriously irrational decision. However, we do not think that the right way to go about solving this problem is to distort explicitly the concept of competence. No good purpose is served by pretending to hold on to the view that no competent patient’s decision should ever be overruled, no matter what the decision is, and then

adopting a concept of competence so that competence is at least partially decided on the basis of whether the decision should be overruled.

In their book, Buchanan and Brock critique an earlier unpublished version of our article and seem to agree with many of the conceptual points we make:

Culver and Gert are correct, we believe, that in the ordinary use of "competence" in many contexts it is a property of a person, not a decision, and is a minimum threshold requirement. They are correct as well that criticism of a person's choices or actions is often in other terms, such as that they are irrational. If we were starting afresh to decide in what terms patients' treatment choices are to be evaluated for whether they should be respected or set aside, and with no prior constraints on how these questions are framed in the law or in medicine, then this fit with ordinary usage would be a reason in favor of Culver and Gert's alternative account of competence. However, we are not starting afresh, but instead are analyzing an ongoing legal and medical practice of evaluating patients' treatment decision making (1989, 67).

They later amplify their concerns about "policy":

[A]n important practical difficulty for Culver and Gert's view is that it would require a fundamental change in the law of informed consent—the rejection of the principle that the voluntary and informed treatment choices of a competent patient must be respected, in favor of the principle that a competent patient's voluntary and informed treatment choices can be set aside on paternalistic grounds if sufficiently irrational. . . . [This principle] would likely be subject to an intolerable level of abuse in practice. . . . Patients who make unusual treatment choices based on unusual values would often find, as already happens now, their choices criticized as irrational by others because those others do not share their values (1989, 69).

We disagree. It is true that the term "irrational" is sometimes used in a loosely pejorative fashion, as is the term "incompetent," but what we and Buchanan and Brock are attempting to do is to replace vague usage with more precise and satisfactory definitions. We do not think it is beyond the competence of clinicians and the courts to stipulate how a term should be used and then to follow that stipulation. If it were the case, which we do not believe, that the term "irrational" is peculiarly subject to linguistic distortion, then some other word or phrase,

like “dangerousness to self without compensating benefit,” could be substituted. Some variation of Buchanan and Brock’s own explication of this concept (1989, 53) could also be used: “Other’s [sic] risk/benefit assessment of that choice in comparison with other alternatives [leads to a] net balance [that is] substantially worse than for another alternative or alternatives.” The central point of our argument is not that the term “irrational” must be used, but that this concept, which we, Drane, and Buchanan and Brock all explicitly employ, must be kept conceptually distinct from the concept of competence.

We are not as daunted as they by the implications of our analysis for the legal system. It is unclear, first of all, what would be involved in changing “the law of informed consent.” Most U.S. jurisdictions have little or no explicit case or statutory law dealing in detail with the matters that concern us here. The few appellate decisions that discuss the definition of competence seem confused and unsatisfactory to us. Thus, it is not as if the courts have set down clear and precise standards for clinicians to follow and that we recommend altering useful and established precedent. The courts might welcome increased conceptual clarity in this area. At any rate, it seems a poor reason to adopt a misleading definition of a concept to say it accords better with a legal tradition that is itself vague and confused.

A recent New York decision (*Rivers v. Katz*)¹ is illustrative of the conceptual confusion to be found in these right-to-refuse-treatment opinions. The New York Court of Appeals (the state’s highest court) held that competent patients could not be given antipsychotic medications against their wishes. How did the court define competence? Early in the opinion competence is defined as “the mental capacity to comprehend the consequences of their decision” (1986, 79). Later the court refers to “their ability to make treatment decisions” (79). Both phrases are consistent with an “understand and appreciate” type of definition of competence.

Still later, however, the court approvingly footnotes the following:

One commentator has suggested that the following factors be considered in evaluating capability to consent or to refuse treatment: (1) the person’s knowledge that he has a choice to make; (2) the pa-

¹*Rivers v. Katz*, NY52d 74 (1986).

tient's ability to understand the available options, their advantages and disadvantages; (3) the patient's cognitive capacity to consider the relevant factors; (4) the absence of any interfering pathologic perception or belief, such as a delusion concerning the decision; (5) the absence of any interfering emotional state, such as severe manic depression, euphoria or emotional disability; (6) the absence of any interfering pathologic motivational pressure; (7) the absence of any interfering pathologic relationship, such as the conviction of helpless dependency on another person; (8) an awareness of how others view the decision, the general social attitude toward the choices and an understanding of his reason for deviating from that attitude if he does (*Rivers v. Katz*, 81).

This throws the definition of competence open so widely that it gives the state practically *carte blanche* about when it wishes to force treatment. A doctor who disagreed strongly with a patient's medication refusal could nearly always claim that the patient was motivated in his refusal by "an interfering pathologic motivational pressure." It seems, in fact, that any treatment decision made in the presence of strong emotion could be called an incompetently made decision, especially because the court does not offer any guidance in discriminating between pathologic and nonpathologic emotions. The court has done something similar to *Drane* and to *Buchanan and Brock*: it has smuggled the concept of rationality into the concept of competence. Because it has done so in a vague and overly broad manner, however, it has suggested guidelines that, if taken seriously, would have exactly the effect the court is trying to avoid: making it easy to overrule a refusing patient.

Our suggestion is to recognize explicitly that competence be interpreted strictly, as the court originally does, as "the mental capacity to comprehend the consequences of their decision" or our equivalent formulation. Competent decisions, moreover, should not be overruled unless they are seriously irrational, that is, there is a serious risk of loss of life, or of serious and permanent disability, with no adequate reason for suffering these evils. We believe that this explicit recognition that serious irrationality or, if one prefers, dangerousness to self, can justify overruling a competent patient's refusal will in fact protect the freedom of competent patients more than the present confused system, which seems to promise more freedom, but in fact delivers less.

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