MISS NORTHERN: No.
JUDGE TODD: I see. All right.
MISS NORTHERN: You are pretty handsome; it's rather nice to have all you handsome men come at you this morning.
MR. SORROW: Can they look at your feet?
MISS NORTHERN: No, no. Can you see me?
JUDGE TODD: I think maybe you better see your feet.
MISS NORTHERN: You know where they are? . . . They are there.
JUDGE TODD: I need to ask you this, Miss Mary. . . . When have you seen your feet?
MR. SORROW: Have you seen them recently? Have they let you see your feet real close?
MISS NORTHERN: They let me see my feet. I can see my feet.
JUDGE TODD: When did you see them, do you remember?
MISS NORTHERN: I seen them two or three times. Don't look at the feet. Let's don't look at the feet.
JUDGE TODD: I tell you what let's do.
MISS NORTHERN: Don't look at the feet.
JUDGE TODD: Let's don't look at the feet. I tell you what let's do. . . . Let's you and I look at them together at the same time and see what we can.
MISS NORTHERN: They are down there.
JUDGE TODD: I want you to look at them with me. Would you do it?
MISS NORTHERN: Isn't—I just don't understand, it's sadism about it. I can't understand it.
A NURSE: Let's all look at your feet.
MISS NORTHERN: Okay. All right, General.
A NURSE: All of us together. Let's get your gown down. There we go. Now—
MISS NORTHERN: That's all peeling off of that. It's all getting well. It's all going down.
JUDGE DROWOTA: Do you have feeling in your feet?
MISS NORTHERN: Oh, yes, they were knocking all around, and they're banging up against this thing and everything.
MR. SORROW: Can you feel it when you do that?
MISS NORTHERN: Yeah.
MR. SORROW: Is there feeling?
MISS NORTHERN: Yeah. . . .
JUDGE TODD: —Would you—would you just bear with us just for one more thing?
MISS NORTHERN: You want to establish your point.
JUDGE TODD: No, we don't. I am asking you—
MISS NORTHERN: You got your points all in writing and established it, according to your own—
JUDGE TODD: Yes, ma'am. If the time comes that you have to choose between losing your feet and dying, would you rather just go ahead and die than lose your feet? If that time comes?
MISS NORTHERN: It's possible—It's possible only if I—Just forget it. I—You are making me sick talking.
JUDGE TODD: I know. I know. And I am sorry. Would you be willing to say to me that you just don't want to live if you can't have your feet? Is that the way you feel?
MISS NORTHERN: I don't understand why it's so important to you people, why it's so important. . . .
JUDGE TODD: Mrs. Mary, you see a judge has to see both sides of the thing, and these people have come and told us something, and now we want you to tell us what you want to tell us so we can decide.
MISS NORTHERN: A billion of you have been here.
JUDGE TODD: I understand. And that's the reason we came out to see you, so we could let you—
MISS NORTHERN: I don't want to discuss it any more. I made my point.
JUDGE TODD: I believe, Mrs. Mary, that you have made your point that you would rather—that you don't want to live if you can't have your feet; isn't that about it?
MISS NORTHERN: That's possible. . . . It's possible to see it that way, to have that opinion. I don't want you all to change your opinion.
JUDGE TODD: No. I want you to tell me if you really feel that way. Tell me because I want to know it. I want to consider how you feel.
JUDGE DROWOTA: Or if you would rather live and have your feet. I mean, without your feet. See, you have got me confused, Miss Mary.
JUDGE TODD: She wants to live and have her feet.
MR. SORROW: That's exactly what she wants.
MISS NORTHERN: This is ridiculous. I am tired. And ridiculous, you know it is.
MR. SORROW: I think they are trying to look at your side of it and understand how you feel, and, of course, somebody else in your position, we don't know what we would do, and so I guess they are saying so many people have told these judges so much they want to see Miss Mary and say, "How do you feel, how do you feel?"
MISS NORTHERN: It's gotten a little roll.

MR. SORROW: Like a snowball.
MISS NORTHERN: This is—Let's leave it alone. Let's leave it alone. And you keep your opinions. I am through with it.
JUDGE TODD: I wish I could be through with it. Let me leave you with a little thought, Miss Mary.
MISS NORTHERN: All right. . . .
JUDGE TODD: Did you ever read the Sermon on the Mount?
MISS NORTHERN: Yes.
JUDGE TODD: You remember one thing the Good Lord said?
MISS NORTHERN: What?
JUDGE TODD: If thy eye offend thee,—
MISS NORTHERN: Oh, yes, take the eye out.
JUDGE TODD: —cast it out. If thy hand offend you, cut it off. Now, if and when your feet begin to offend you, maybe, maybe, you will remember that little verse.
MISS NORTHERN: I thank you.

Deciding for Others: Competency

Allen Buchanan and Dan W. Brock

COMPETENCE AND INCOMPETENCE

Discussions of competence have often been hampered by a failure to distinguish carefully among the following questions:

- What is the appropriate *concept* of competence?
- Given an analysis of the appropriate concept of competence, what *standard* (or standards) of competence must be met if an individual is to be judged to be competent?
- What are the most reliable *operational measures* for ascertaining whether a given standard of competence is met?
- *Who* ought to make a determination of competence?
- What *sorts of institutional arrangements* are needed to assure that determinations of competence are made in an accurate and responsible way?

Each of these questions will be addressed separately. This section—which is concerned with the theoretical underpinnings of determinations of competence—will concentrate on the first three questions. The last two, which raise more practical and concrete concerns, can only be addressed in detail after the ethical framework has been laid out and the realities of current practices have been described.

From *Milbank Quarterly*, 64:2, 1986, 67–80. Reprinted with permission from Blackwell Publishers.

EDITOR'S NOTE: References have been cut. Readers wishing to follow up sources should consult the original article.

THE CONCEPT OF COMPETENCE

COMPETENCE AS DECISION-RELATIVE

The statement that a particular individual is (or is not) competent is incomplete. Competence is always competence *for some task*—competence *to do something*. The concern here is with competence to perform the task of making a decision. Hence, competence is to be understood as *decision-making capacity*. But the notion of decision-making capacity is itself incomplete until the nature of the choice as well as the conditions under which it is to be made are specified. Thus competence is decision-relative, not global. A person may be competent to make a particular decision at a particular time, under certain circumstances, but incompetent to make another decision, or even the same decision under different conditions. A competency determination, then, is a determination of a particular person's capacity to perform a particular decision-making task at a particular time and under specified conditions.

Any individual may be competent to perform some tasks (e.g., drive a car), but not others (e.g.,

solve differential equations). The tasks relevant to this article vary substantially, and include making decisions about medical treatment, entering into contracts, deciding whether to continue to live on one's own in an unsupervised setting, and so forth. It is true, of course, that for some individuals, decision-making capacity is entirely lacking (for instance, when the individual is permanently unconscious), but these are the unproblematic cases.

Decision-making tasks vary substantially in the capacities they require for performance at an appropriate level of adequacy. For example, even restricted to medical treatment decisions, there is substantial variation in the complexity of information that is relevant to a particular treatment decision and that, consequently, must be understood by the decision maker. There is, therefore, variation in what might be called the *objective demands* of the task in question—here, the level of abilities to understand, reason, and decide about the options in question. But there is also variation of several sorts in a subject's ability to meet the demands of a particular decision. Many factors that diminish or eliminate competence altogether vary over time in their presence or severity in a particular person. For example, the effects of dementia on a person's cognitive capacities is at some stages commonly not constant, particularly in cases of borderline competence. Instead, mental confusion may come and go; periods of great confusion are sometimes followed by comparative lucidity.

In other cases, the environment and the behavior of others may affect the relative level of decision-making competence. For example, side effects of medications often impair competence, but a change of medication may reduce those effects. Behavior of others may create stresses for a person that diminish decision-making capacities, but that behavior can often be altered, or the situations in which it occurs can be avoided. Further, cognitive functioning can sometimes be enhanced by familiar surroundings and diminished by unfamiliar ones. A person may be competent to make a decision about whether to have an elective surgical procedure if the choice is presented in the familiar surroundings of home by someone known and trusted, but may be incompetent to make that same choice in what is found to be the intimidating, confusing, and unfamiliar environment of a hospital.

Factors such as these mean that even for a given decision, a person's competence may vary over time, and so be intermittent. The values that support the right of the competent person to participate in health care decisions also require that caretakers utilize periods of lucidity when they occur. Sometimes the emergency nature of the situation will not permit this, but it is no doubt possible to involve intermittently competent persons in decision making substantially more than is done at present. Sometimes, with opportune timing or other appropriate measures (such as medications), the intermittently competent person may be able to be involved in decision making at a time when he or she is clearly competent. Often, however, the person either consistently remains in, or can only be brought to, a state of borderline competence for the decision at hand. These borderline cases of questionable competence require more careful analysis of and clarity about the nature of the competency determination. They also illustrate the need for greater sophistication on the part of medical care providers and others about physical and mental problems that frequently affect the elderly.

CAPACITIES NEEDED FOR COMPETENCE

What capacities are necessary for a person competently to decide about such matters as health care, living arrangements, financial affairs, and so forth? As already noted, the demands of these different decisions will vary, but it is nevertheless possible to generalize about the necessary abilities. Two may be distinguished: the capacity for communication and understanding, and the capacity for reasoning and deliberation. Although these capacities are not entirely distinct, significant deficiencies in any of them can result in diminished decision-making competence. A third important element of competence is that the individual must have a set of values or conception of the good.

Under *communication and understanding* are included the various capacities that allow a person to take part in the process of becoming informed on and expressing a choice about a given decision. These include the ability to communicate and the possession of various linguistic, conceptual, and cognitive abilities necessary for an understanding of the particular information relevant to the decision at hand. The relevant cognitive abilities, in particular, are often impaired by disease processes

to which the elderly are especially subject, including most obviously various forms of dementia, but also aphasia due to stroke and, in some cases, reduced intellectual performance associated with depression (pseudodementia). Even where cognitive function is only minimally impaired, ability to express desires and beliefs may be greatly diminished or absent (as in some patients with amyotrophic lateral sclerosis).

Understanding also requires the ability to appreciate the nature and meaning of potential alternative—what it would be and "feel" like to be in possible future states and to undergo various experiences. In young children this is often prevented by the lack of sufficient life experience. In the case of elderly persons facing diseases with progressive and extremely debilitating deterioration, it is hindered by people's generally limited ability to understand a kind of experience radically different from their own and by the inability of severely impaired individuals to communicate the character of their own experience to others. Major psychological blocks—such as fear, denial, and depression—can also significantly impair the appreciation of information about an unwanted or dreaded alternative. In general, communication and understanding require the capacities to receive, process, and make available for use the information relevant to particular decisions.

Competence also requires *capacities for reasoning and deliberation*. These include capacities to draw inferences about the consequences of making a certain choice and to compare alternative outcomes based on how they further one's good or promote one's ends. Some capacity to employ rudimentary probabilistic reasoning about uncertain outcomes will commonly be necessary, as well as the capacity to give due consideration to potential future outcomes in a present decision. Reasoning and deliberation obviously make use of both capacities mentioned earlier: understanding the information and applying the decision maker's values.

Finally, a competent decision maker also requires a *set of values or conception of what is good* that is reasonably consistent and stable. This is needed in order to be able to evaluate particular outcomes as benefits or harms, goods or evils, and to assign different relative weight or importance to them. Often what will be needed is the capacity to decide on the import and relative weight to be accorded different values, since that may not have been fully determined before a particular choice must be made. Competence does not require a fully consistent set of goals, much less a detailed "life plan" to cover all contingencies. Sufficient internal consistency and stability over time in the values relative to a particular decision, however, are needed to yield a decision outcome. Although values change over time and although ambivalence is inevitable in the difficult choices faced by many persons of questionable competence concerning their medical care, living arrangements, and personal affairs, sufficient value stability is needed to permit, at the very least, a decision that can be stated and adhered to over the course of its discussion, initiation, and implementation.

COMPETENCE AS A THRESHOLD CONCEPT, NOT A COMPARATIVE ONE

Decision-making competence, and the skills and capacities necessary to it, is one of the three components in standard analyses of the requirements for informed consent in health care decision making. The informed-consent doctrine requires the free and informed consent of a competent patient to medical procedures that are to be performed. The idea underlying this doctrine is that of a patient deciding, in consultation with a physician, what health care, if any, will best serve the patient's aims and needs. If the decision is not voluntary, but instead coerced or manipulated, it will likely serve another's ends or another's view of the patient's good, not the patient's own view, and will, in a significant sense, originate with another and not the patient. If the appropriate information is not provided to the individual in a form the patient can understand, the patient will not be able to ascertain how available alternatives might serve his or her aims. Finally, if the patient is not competent, either the individual will be unable to decide at all or the decision-making process will be seriously flawed.

Sometimes incompetence will be uncontroversially complete, as with patients who are in a persistent vegetative state or who are in a very advanced state of dementia, unable to communicate coherently at all. Often, however, defects in the capacities and skills noted above as necessary to competence will be partial and a matter of degree, just as whether a patient's decision is voluntary or involuntary, informed or uninformed, is

also often a matter of degree. Does this mean that competence itself should be thought of as sometimes partial and possessed in different degrees? It is certainly the case that persons are commonly thought of and said to be more or less competent to perform many tasks, not just decision making. Nevertheless, because of the role competency determinations play in health care generally, and in the legal process in particular, it is important to resist the notion that persons can be determined to be more or less competent, or competent to some degree. The difficulty with taking literally the notion that competence is a matter of degree can be seen clearly by looking at the function of the competency determination within the practice of informed consent for health care, or within other areas of the law in which it plays a role, such as conservatorship or guardianship for financial affairs.

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 be designated as surrogate decision makers. The function of the competency determination, then, is to make an "all or nothing" classification of persons with regard to their competence to make particular decisions, not to make "matter of degree" findings about their decision-making capacities and skills. 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—even though the underlying capacities and skills forming the basis of that judgment are possessed in different degrees. Competence, then, is in this sense a threshold concept, not a comparative one.

The foregoing makes clear that the crucial question in the competency determination is *how* defective an individual's capacities and skills to make a particular decision must be for the individual to be found incompetent to make that decision, so that a surrogate decision maker becomes necessary. In keeping with the primary objective of this article, the analysis of that question focuses on medical decisions. Here, the familiar doctrine of informed consent provides considerable guidance.

The central purpose of assessing competence is to determine whether a patient may assert his or her right to decide to accept or refuse a particular medical procedure, or whether that right shall be transferred to a surrogate. We must, therefore, ask what values are at stake in whether people are allowed to make such decisions for themselves. The informed-consent doctrine assigns the decision-making right to patients themselves; but what fundamental values are served by the practice of informed consent? In the literature dealing with informed consent, many different answers—and ways of formulating answers—to that question have been proposed, but we believe the most important values at stake are: (1) promoting and protecting the patient's well-being, and (2) respecting the patient's self-determination. It is in examining the effect of these two values that the answer to the proper standard of decision-making competence will be found.

STANDARDS OF COMPETENCE: UNDERLYING VALUES

PROMOTION OF INDIVIDUAL WELL-BEING

There is a long tradition in medicine that the physician's first and most important commitment should be to serve the well-being of the patient. The more recent doctrine of informed consent is consistent with that tradition, if it is assumed that, at least in general, competent individuals are better judges of their own good than others are. The doctrine recognizes that while the physician commonly brings to the physician-patient encounter medical training that the patient lacks, the patient brings knowledge that the physician lacks: knowledge of particular subjective aims and values that are likely to be affected by whatever decision is made.

As medicine's arsenal of possible interventions has dramatically expanded in recent decades, alternative treatments (and the alternative of no treatment) now routinely promise different mixes of benefits and risks to the patient. Moreover, since health is only one value among many, and is assigned different importance by different persons, there is commonly no one single intervention for a particular condition that is best for everyone. Which, if any, intervention best serves a particular patient's well-being will depend in part on that patient's aims and values. Health care decision making thus usually ought to be a joint undertaking between physician and patient, since each brings knowledge and experience that the other lacks, yet that is necessary for decisions that will best serve the patient's well-being.

In the exercise of their right to give informed consent, then, patients often decide in ways that they believe will best promote their own well-being as they conceive it. As is well known, and as physicians are frequently quick to point out, however, the complexity of many treatment decisions—together with the stresses of illness with its attendant fear, anxiety, dependency, and regression, not to mention the physical effects of illness itself—means that a patient's ordinary decision-making abilities are often significantly diminished. Thus, a patient's treatment choices may fail to serve his or her good or well-being, even as that person conceives it. Although one important value requiring patient participation in their own health care decision making is the promotion of patient well-being, that same value sometimes also requires persons to be protected from the harmful consequences to them of their own choices.

RESPECT FOR INDIVIDUAL SELF-DETERMINATION

The other principal value underlying the informed-consent doctrine is respect for a patient's self-determination, understood here as a person's interest in making important decisions about his or her own life. Although often conceived in the law under the right to privacy, the leading legal decisions in the informed-consent tradition appeal fundamentally to the right of individual self-determination. No attempt will be made here to analyze the complex of ideas giving context to the concept of individual self-determination, nor of the various values that support its importance. But it is essential to underline that many persons commonly want to make important decisions about their life for themselves, and that desire is in part independent of whether they believe that they are always in a position to make the best choice. Even when we believe that others may be able to decide for us better than we ourselves can, we sometimes prefer to decide for ourselves so as to be in charge of and responsible for our lives.

The interest in self-determination should not be overstated, however. People often wish to make such decisions for themselves simply because they believe that, at least in most cases, they are in a better position to decide what is best for themselves than others are. Thus, when in a particular case others are demonstrably in a better position to decide for us than we ourselves are, a part, but not all, of our interest in deciding for ourselves is absent.

CONFLICT BETWEEN THE VALUES OF SELF-DETERMINATION AND WELL-BEING

Because people's interest in making important decisions for themselves is not based solely on their concern for their own well-being, these two values of patient well-being and self-determination can sometimes conflict. Some people may appear to decide in ways that are contrary to their own best interests or well-being, even as determined by their own settled conception of their good, and others may be unable to convince them of their mistake. In other cases, others may know little of a person's own settled values, and the person may simply be deciding in a manner sharply in conflict with how most reasonable persons would decide. It may be difficult or even impossible to determine, however, whether this conflict is simply the result of a difference in values between this individual and most reasonable persons (for example, a difference in the weights assigned to various goods), or whether it results from some failure of the patient to assess correctly what will best serve his or her own interests or good.

In the conflict between the values of self-determination and patient well-being, a tradeoff between avoiding two kinds of errors should be sought. The first error is that of failing to protect a person from the harmful consequences of his or her decision when the decision is the result of serious defects in the capacity to decide. The second error is failing to permit someone to make a decision and turning the decision over to another, when the patient is able to make the decision him or herself. With a stricter or higher standard for competence, more people will be found incompetent, and the first error will be minimized at the cost of increasing the second sort of error. With a looser or more minimal standard for competence, fewer persons will be found incompetent, and the second sort of error is more likely to be minimized at the cost of increasing the first.

Evidence regarding a person's competence to make a particular decision is often uncertain,

incomplete, and conflicting. Thus, no conceivable set of procedures and standards for judging competence could guarantee the elimination of all error. Instead, the challenge is to strike the appropriate balance and thereby minimize the incidence of either of the errors noted above. No set of procedures will guarantee that all and only the incompetent are judged to be incompetent.

But procedures and standards for competence are not merely inevitably imperfect. They are inevitably *controversial* as well. In the determination of competence, there is disagreement not only about which procedures will minimize errors, but also about the proper standard that the procedures should be designed to approximate. The core of the controversy derives from the different values that different persons assign to protecting individuals' well-being as against respecting their self-determination. We believe there is no uniquely "correct" answer to the relative weight that should be assigned to these two values, and in any event it is simply a fact that different persons do assign them different weight.

DECIDING ON STANDARDS OF COMPETENCE

Focusing only on the two values of patient well-being and self-determination is an oversimplification. Because other values are at stake, room for controversy about the proper standard of competence increases. For example, also important to the appropriate standard of competence is the value of maintaining public confidence in the integrity of the medical profession, so as to protect and foster the trust necessary to physician-patient relationships that function well.

The standard of competence, then, cannot be discovered. There is no reason to believe that there is one and only one optimal tradeoff to be struck between the competing values of well-being and self-determination, nor, hence, any one uniquely correct level of capacity at which to set the threshold of competence — even for a particular decision under specified circumstances. In this sense, setting a standard for competence is a value choice, not a scientific or factual matter. Nevertheless, the choice need not be and should not be arbitrary. Instead, it should be grounded in (1) a reflective appreciation of the values in question, (2) a clear understanding of the goals that the determination of competence is to serve, and (3) an accurate prediction of the practical consequences of setting the threshold at this level rather than elsewhere.

People may disagree on exactly where the threshold should be set not only because they assign different weights to the values of self-determination and well-being, but also because they make different estimates of the probability that others will err in trying to promote a person's interests. Unanimous agreement on an optimal standard is not necessary, however, for workable social arrangements for determining competence, any more than it is for determining who may vote or who may drive an automobile.

DIFFERENT STANDARDS OF COMPETENCE

A number of different standards of competence have been identified and supported in the literature, though statutory and case law provide little help in articulating precise standards. It is not feasible to discuss here all the alternatives that have been proposed. Instead, the range of alternatives will be delineated and the difficulties of the main standards will be examined.

No single standard is adequate for all medical treatment decisions, much less so for decisions about living arrangements, financial affairs, participation in research, and so forth. It was argued above that a standard of competence must set a balance between the two principal values at stake in health care decision making: promoting and protecting the patient's well-being while respecting the patient's self-determination.

An example of a minimal standard of competence is that the patient merely be able to express a preference. This standard respects every expressed choice of a patient, and so is not, in fact, a criterion of *competent* choice at all. It entirely disregards whether defects or mistakes are present in the reasoning process leading to the choice, whether the choice is in accord with the patient's conception of his or her good, and whether the choice would be harmful to the patient. It thus fails to provide any protection for patient well-being, and it is insensitive to the way the value of self-determination itself varies with differences in people's capacities to choose in accordance with their conceptions of their own good.

At the other extreme are standards that look to the *content* or *outcome* of the decision, for example,

the standard that the choice be a reasonable one, or be what other reasonable or rational persons would choose. On this view, failure of the patient's choice to match some such allegedly objective standard of choice entails that it is an incompetent choice. Such a standard maximally protects patient well-being—according to the standard's conception of well-being—but fails adequately to respect patient self-determination.

At bottom, a person's interest in self-determination is his or her interest in defining, revising over time, and pursuing his or her own particular conception of the good life. There are serious risks associated with any purportedly objective standard for the correct decision—the standard may ignore the patient's own distinctive conception of the good and may involve the substitution of another's conception of what is best for the patient. Moreover, even such a standard's claim to protect maximally a patient's well-being is only as strong as the objective account of a person's well-being on which the standard rests.

The issue is theoretically complex and controversial, but any standard of individual well-being that does not ultimately rest on an individual's own informed preferences is both problematic in theory and subject to intolerable abuse in practice. Thus, a standard that judges competence by comparing the content of a patient's decision to some objective standard for the correct decision may fail even to protect appropriately a patient's well-being. An adequate standard of competence will focus primarily not on the content of the patient's decision, but on the *process* of reasoning that leads up to that decision.

While an adequate competency evaluation and standard focuses on the patient's understanding and reasoning, rather than upon the particular decision that issues from them, the key issue remains. What level of reasoning is required for the patient to be competent? In other words, how well must the patient understand and reason to be competent? How much can understanding be limited or reasoning be defective and still be compatible with competence? It is important to emphasize another question faced by those evaluating competence. How certain must those persons evaluating competence be about how well the patient has understood and reasoned in coming to a decision? This last question is important because it is common in cases of marginal or questionable competence for there to be a significant degree of uncertainty about the patient's decision-making process that can never be eliminated.

RELATION OF THE STANDARD OF COMPETENCE TO EXPECTED HARMS AND BENEFITS

Because the competency evaluation requires setting a balance between the two values of respecting patients' rights to decide for themselves and protecting them from the harmful consequences of their own choices, it should be clear that no single standard of competence—no single answer to the questions above—can be adequate. That is simply because the degree of expected harm from choices made at a given level of understanding and reasoning can vary from virtually none to the most serious, including major disability or death.

There is an important implication of this view that the standard of competence ought to vary with the expected harms or benefits to the patient of acting in accordance with a 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.

Because the appropriate level of competence properly required for a particular decision must be adjusted to the consequences of acting on that decision, no single standard of decision-making competence is adequate. Instead, the level of competence appropriately required for decision making varies along a full range from low/minimal to high/maximal. Table 1 illustrates this variation.

The presumed net balance of expected benefits and risks of patient choice in comparison with other alternatives refers to the physician's assessment of the expected effects in achieving the goals of prolonging life, preventing injury and disability, and relieving suffering from a particular treatment option as against its risks of harm. The table indicates that the relevant comparison is with other available alternatives, and the degree to which the net benefit/risk balance of the alternative chosen is better or worse than that for other treatment options. It should be noted that a choice might properly require only low/minimal competence,

Table 1. Decision-Making Competence and Patient Well-Being

Presumed net balance of expected benefits and risks of patient choice in comparison with other alternatives	Level of decision-making competence required	Grounds for believing patient's choice best promotes/protects own well-being
Net balance substantially better than for possible alternatives.	Low/minimal	Principally the benefit/risk assessment made by others.
Net balance roughly comparable to that of other alternatives.	Moderate/median	Roughly equally from the benefit/risk assessment made by others and from the patient's decision that the chosen alternative best fits patient's conception of own good.
Net balance substantially worse than for another alternative or alternatives.	High/maximal	Principally from patient's decision that the chosen alternative best fits own conception of own good.

although its expected risks exceeded its expected benefits, because all other available alternatives had substantially worse expected risk/benefit ratios.

Table 1 also indicates, for each level of competence, the grounds for believing that a patient's own choice best promotes his or her well-being. This brings out an important point. For all patient choices, other people responsible for deciding whether those choices should be respected should have grounds for believing that the choice, if it is to be honored, is reasonably in accord with the patient's good and does reasonably protect or promote the patient's well-being (though the choice need not, of course, *maximize* the patient's interests). When the patient's level of decision-making competence is only at the low/minimal level, the grounds derive only minimally from the fact that the patient has chosen the option in question; they principally stem from others' positive assessment of the choice's expected effects for life and health.

At the other extreme, when the expected effects of the patient's choice for life and health appear to be substantially worse than available alternatives, the requirement of a high/maximal level of competence provides grounds for relying on the patient's decision as itself establishing that the choice best fits the patient's good (his or her own particular aims and ends). That highest level of competence is required to rebut the presumption that if the choice seems not best to promote life and health, then that choice is not, in fact, reasonably related to the patient's interests.

When the expected effects for life and health of the patient's choice are approximately comparable to those of alternatives, a moderate/median level of competence is sufficient to provide reasonable grounds that the choice promotes the patient's good and that his or her well-being is adequately protected. It is also reasonable to assume that as the level of competence increases (from minimal to maximal), the value or importance of respecting the patient's self-determination increases as well, since a part of the value of self-determination rests on the assumption that persons will secure their good when they choose for themselves. As competence increases, the likelihood of this happening increases.

Thus, according to the concept of competence endorsed here, a particular individual's decision-making capacity at a given time may be sufficient for making a decision to refuse a diagnostic procedure when forgoing the procedure does not carry a significant risk, although it would not necessarily be sufficient for refusing a surgical procedure that would correct a life-threatening condition. The greater the risk—where risk is a function of the severity of the expected harm and the probability of its occurrence—the greater the level of communication, understanding, and reasoning skills required for competence to make that decision. It is not always true, however, that if a person is competent to make one decision, then he or she is competent to make another decision so long as it involves equal risk. Even if this risk is the same, one decision may be more complex, and hence require a higher level of capacity for understanding options and reasoning about consequences.

RELATION OF REFUSAL OF TREATMENT TO DETERMINATION OF INCOMPETENCE

A common criticism of the way physicians actually practice is that patients' competence is rarely questioned until they refuse to consent to a physician's recommendation for treatment. It is no doubt true that patients' competence when they accept physicians' treatment recommendations should be questioned more often than it now is, because consent without understanding provides little basis for believing the choice is best for the patient, and because the physician's judgment about what is medically best is fallible. Nevertheless, treatment refusal does reasonably raise the question of a patient's competence in a way that acceptance of recommended treatment does not. It is a reasonable assumption that physicians' treatment recommendations are more often than not in the interests of their patients. Consequently, it is a reasonable presumption—though rebuttable in any particular instance—that a treatment refusal is contrary to the patient's interest. Exploration of the reasons for the patient's response, including determination of whether the decision was a competent one, are appropriate—though reassessment of the recommendation is often appropriate as well.

It is essential to distinguish here, however, between grounds for calling a patient's competence into question and grounds for a finding of incompetence. Treatment refusal does reasonably serve to trigger a competency evaluation. On the other hand, a disagreement with the physician's recommendation or refusal of a treatment recommendation is no basis whatsoever for a finding of incompetence. This conclusion follows from the premise noted earlier that the competency evaluation, as well as evidence in support of a finding of incompetence, should address the *process* of understanding and reasoning of the patient, *not* the *content* of a decision.

Another essential distinction is between two quite different types of treatment refusal: a refusal of all the treatment options offered, and refusing the one treatment that the physician believes to be best while accepting an alternative treatment that lies within the range of medically sound options. If there is more than one medically sound treatment option—in the sense that competent medical judgment is divided as to which of two or more treatments would be optimal—then the patient's refusal to accept the option that the physician believes is optimal should not even raise the question of the patient's competence, much less entail a finding of incompetence, at least so long as the option the patient chooses lies within the range of medically sound options.

CONTRAST WITH FIXED MINIMUM THRESHOLD CONCEPTION OF COMPETENCE

Before elaborating the implications of this analysis for operational measurements of competence, it will be useful to contrast it with a widely held alternative conception that has been implicitly rejected here. According to this other conception—which may be called the "fixed minimal capacity" view—competence is *not* decision-relative. The simplest version of this view holds that a person is competent if he or she possesses the relevant decision-making capacities at some specified level, regardless of whether the decision to be made is risky or nonrisky, and regardless of whether the information to be understood or the consequences to be reasoned through are simple or complex. This concept of competence might also be called the "minimal threshold status concept," since the idea is that if a person's decision-making capacities meet or exceed the specified threshold, then the status of being a *competent individual* is to be ascribed to that person. According to this view, competence is an attribute of persons dependent solely on the level of decision-making capacities they possess (though these may vary, of course, from day to day or even from hour to hour, depending upon the effects of disease, medications, emotional states, and so on).

In contrast, according to the conception of competence espoused here, competence is a *relational* property. Whether a person is competent to make a given decision depends not only upon that person's own capacities but also upon certain features of the decision—including risk and information

requirements. There are at least five points in favor of this approach.

First, a concept that allows a raising or lowering of the standard for decision-making capacities depending upon the risks of the decision in question is clearly more consonant with the way people actually make informal competency determinations in areas of judgment in which they have the greatest confidence and in which there is the most consensus. For example, you may decide that your 5-year-old child is competent to choose between a hamburger and a hotdog for lunch, but you would not think the child competent to make a decision about how to invest a large sum of money. This is because the risk in the latter case is greater, and the information required for reasoning about the relevant consequences of the options is much more complex. It is worth emphasizing that incompetence due to developmental immaturity, as in the case of a child, is in many respects quite different from the increasing incompetence due to a degenerative disease such as Alzheimer's. These and other cases of incompetence do have in common, however, the relevance of the degree of risk for determining the appropriate level of competence.

Second, the decision-relative concept of competence also receives indirect support from the doctrine of informed consent. The more risky the decision a patient must make, and the more complex the array of possible benefits and burdens, the greater the amount of information that must be provided and the higher the standard of understanding required on the part of the patient. For extremely low-risk procedures, with a clear and substantial benefit and an extremely small probability of significant harm, the information that must be provided to the patient is correspondingly less.

Third, perhaps the most important reason for preferring the decision-relative concept of competence is that it better coheres with our basic legal framework in two distinct respects. First, in its treatment of minors, the law has already tacitly adopted the decision-relative concept and rejected the minimum threshold concept. The courts as well as legislatures now recognize that a child can be competent to make some decisions but not others—that competence is not an all-or-nothing status—and that features of the decision itself (including risk) are relevant factors in determining whether the child is competent to make that decision. This approach is increasingly popular, and is utilized in, for example, "limited conservatorships," where some decision-making authority is expressly left with the conservatee.

In addition, the law in this country has, in general, steadfastly refused to recognize a right to interfere with a *competent* patient's voluntary choice on purely paternalistic grounds—that is, solely to prevent harms or to secure benefits for the competent patient him or herself. Instead, the law makes a finding of incompetence a necessary condition for justified paternalism. According to the decision-relative concept of competence, the greater the potential harm to the individual, the higher the standard of competence. From this it follows that a finding of incompetence is more likely in precisely those instances in which the case for paternalism is strongest—cases in which great harm can be easily avoided by taking the decision out of the individual's hands. Thus, the concept of competence favored here allows paternalism in situations in which the case for paternalism seems strongest, while at the same time preserving the law's fundamental tenet that, in general, people may be treated paternalistically only when they are incompetent to make their own decisions.

The fourth reason for preferring the decision-relative concept of competence is that it allows a finding of incompetence for a particular decision to be limited to that decision, and so it is not equivalent to a change in the person's overall status as a decision maker. Consequently, the decision-relative concept of competence contains a built-in safeguard to allay the fear that paternalism—even if justified in a particular case considered in isolation—is likely to spill over into other areas, eventually robbing the individual of all sovereignty over his or her own life. Further, any finding of incompetence is likely to evoke strong psychological reactions from some patients because to be labeled as "an incompetent" is to be returned to a childlike status. By making it clear that incompetence is decision-relative and hence may be limited to certain areas, the concept of competence used here can at least minimize the potentially devastating assault on self-esteem that a finding of incompetence represents to some individuals.

Finally, the decision-relative concept of competence has another clear advantage over the minimum threshold concept: It allows a better balance between the competing values of self-determination and well-being that are to be served by a determination of competence. The alternative concept, on its most plausible interpretation, also represents a balancing of these fundamental values, but in a cruder fashion (Brock 1983). Setting a minimal threshold of decision-making capacities represents a choice about the proper balance of tradeoff between respect for self-determination and concern for well-being, but it does so on the basis of an extremely sweeping, unqualified generalization—about the probability that unacceptable levels of harm will occur if individuals are left free to choose—over an indefinitely large number of highly diverse potential decisions.

But as indicated earlier, decisions can vary enormously in their information requirements, in the reasoning ability needed to draw inferences about relevant consequences, and in the magnitude of risk involved. Hence, any such sweeping generalization will be very precarious. If the generalization errs in one direction—by underestimating the overall harm that would befall individuals if the threshold for competence were set at one level—then the minimal threshold of decision-making capacities will be set so low that many people who are judged competent will make disastrous choices. If the generalization errs in the other direction—by overestimating the harm that would result if the threshold were set at a particular level—then many people will be interfered with for no good reason. Thus, regardless of where the minimal threshold is set, it seems likely that it will provide either too much protection or too little. The decision-relative concept of competence avoids relying upon such crude generalizations about harm and permits a finer balance to be struck between the goods of protecting well-being and respecting self-determination.

A Chronicle: Dax's Case As It Happened

Keith Burton

. . . The story of Don Cowart is remarkable in some ways but commonplace in others. A man's wish to die is rather extraordinary in and of itself; but the pattern of events that shapes such a wish often is woven of the fabric of life's everyday occurrences. Such is the case with Cowart.

Ray and Ada Cowart moved their family from the Rio Grande Valley to the small East Texas town of Henderson in the sixties. Ray prospered over the years as a rancher and real estate agent. Ada became a teacher in the Henderson school district. Their three children—Don, Jim, and Beth—were no different from other kids reared in a close-knit community. In fact, they were ordinary people living ordinary lives.

"Donny Boy," as he came to be called by his father, was popular in school and excelled in athletics. He was captain of his high school football team and performed in rodeos. He liked to take risks, a trait that often dismayed his mother. It was risk taking that would later lure him to skydiving, surfing, and other sports of chance.

Don Cowart left Henderson in 1966 to attend the University of Texas at Austin. He had planned to return home at his graduation three years later to join his father in business; however, when notified of his military draft selection, Cowart instead elected to join the U.S. Air Force. He became a pilot and served in Vietnam. He married a high school sweetheart in 1972, but they divorced eight months later. In May 1973 he was discharged from active duty and returned to Henderson, where he began working with his father in real estate.

July 23, 1973, seemed no different to Cowart from any other Wednesday. It was hot and sultry as the afternoon sun slipped low along the pine trees in the countryside near Henderson. Ray and Don had driven out to a ranch to look over some property being offered for sale by the owner. They parked their car on a bridge over a dry creek and took off by foot. They talked and laughed together as they surveyed points of interest on the land. Their business completed, the Cowarts then returned to their car to go home for dinner.

The accident happened with no warning. The Cowart men had returned to their car but had not been able to start the engine. Ray had lifted the hood and removed the air cleaner from the engine. He primed the

From *Dax's Case: Essays in Medical Ethics and Human Meaning*, edited by Lonnie D. Kliever, Southern Methodist University Press, 1989. Reprinted with permission.