

Week 5 Reading SAL: Capacity and the competent patient

Brock and Buchanan: *Deciding for Others*

A; The concept

A competency determination is determination of a particular person's ability to perform a particular decision-making task at a particular time under specified conditions.

A competent person has linguistic, conceptual and cognitive abilities to communicate; the ability imagine alternative states; ability to receive, process and express.

A competent person can reason and deliberate; draw inferences about the consequences of choices and compare results of alternatives.

A competent person has a set of values or a stable and consistent conception of the good; priorities that can be weighed.

B & B claim that competence is a *threshold* concept, not a *comparative* one: Although the abilities that contribute to capacity may vary, people have to be judged to fall on one side of a line or the other, depending upon whether they are judged able to decide for themselves or need to have decisions made by a surrogate.

B: Standards of competency:

The two values that justify our emphasis on capacity are

--Promotion of individual well-being (=beneficence)

--Respect for individual self-determination (=autonomy)

In cases where the two standards yield differing results, it can be difficult to determine whether the person fails to understand the issues, or has a different value- hierarchy. You are always vacillating between two possible errors: failing to protect the chooser from the harmful consequences of a choice made with inadequate capacity, or taking decisions away from a capable chooser. Different people, asked to determine the decision-making capacity of someone else, may tend more to one error than the other, but that can't be helped.

C: Deciding upon operational measures of competence in specific cases

We need to accept that this is a value choice, not a scientific determination. But it can be a better choice or a worse one depending upon whether there is (a) a reflective appreciation of the values at stake; (b) a clear understanding of the desired goal of determining competence, and (c) a good prediction of the consequences of setting the threshold at a higher or lower level in this case.

If the person deciding Y's competence sets a *minimal* standard, the ability to express a preference may suffice, in which case individual well-being can be threatened. On the other hand, requiring that the standard of Y's competence be '*what the reasonable person would decide*' may undervalue patient self-determination. So the important thing is to look at the process of reasoning leading to the decision—not its content.

The degree of competence required to make decisions should be higher as the risk of the suggested procedure increases. (See chart p.375). If the harm to be expected is great and the probability of it is high, you have to evidence a high level of understanding and reasoning in order for your refusal to accept a proposed treatment to be unquestioned. Indeed, because of the knowledge imbalance between physician and patient, it is in general reasonable to demand a higher level of competence in order to refuse treatments than to accept them.

B&B are recommending a *decision-relative standard of competence* (which they contrast with a ‘fixed minimal capacity’ view on p. 377). It requires greater capacity to refuse a life-sustaining treatment than to agree to it. [SAL, p. 327, ask: “Does this sliding-scale approach mask ethically problematic paternalistic judgments as objective ...determinations...or ...does it correctly avoid attributing autonomy to all conscious patients, regardless of cognitive impairment?”]

They give 5 reasons for preferring it: it is more in line with the way we make judgments of competence in other areas of life; it is supported by the practical demands of our doctrine of informed consent; it coheres with our basic legal framework, it limits judgments of incompetence to particular contexts, rather than making them global, and it allows for better balancing of the two fundamental values of self-determination and well-being that underlie our understanding of capacity.

Legal background: In reaction to some uncertainty about what degree of evidence of prior wishes is necessary in order for surrogate decision makers to withdraw life sustaining treatment [cf. Quinlan and SAL p. 327] in 1976 California passed the Natural Death Act, the first law to authorize advance directives. In 1991 congress passed the Patient Self-Determination Act, and more than 40 states have enacted comparable laws. That’s where the order of surrogates comes from]

Annas: The Health Care Proxy and the Living Will (1991)

Annas discusses the health care power of attorney and its advantages over an advance directive form, and refers to the second most crucial ‘withdrawal of treatment by surrogates’ case—*Cruzan*.

Advance directives provide legal immunity to physicians who follow them; they are applicable only to the ‘terminally ill,’ a possibly vague category; they usually limit the kinds of treatments that they allow to be refused or withdrawn, and there is no penalty for failing to honor them.

Every state has a ‘durable power of attorney’ law which allows for naming a designated person to make decisions. The health care proxy is a second-generation version of the advance directive and avoids some of its difficulties in interpretation and application, although it is not a solution to all end-of-life decisions.

Fagerlin & Schneider: Enough: The Failure of the Living Will (2004)

Lots of people still strongly advocate ‘living wills; but we think they have been shown to be an idea that failed.

We don’t include durable power of attorney in our condemnation. And we aren’t against them on principle: we don’t reject the idea of ‘precedent autonomy,’ per se. We even think that there are particular situations when they are very useful: for people whose medical situation is clear, crisis is imminent and preferences are clear and strong.

But we are against them as a policy—made universal, routine—despite the fact that there is a great deal of support for them on the legislative, judicial, and administrative levels, as well as from professional associations.

Proponents and advocates claim that the only problem is that not enough people have them. They are, if nothing else, useful for providing an occasion to open a

conversation about end of life preferences. Some advocates want the durable power of attorney for health care to include an advance directive section.

We maintain that living wills would only work under the following 5 conditions:
--if everyone had one;
--if the people concerned can decide what they would want;
--those preferences are stated very clearly
--the relevant paperwork was always present and accessible; and
--the indicated preferences are always followed.

But:

--Not everyone does have one; indeed, in various surveys, it seems that 82% of people don't want one; and over 70% of people prefer to leave the decisions to others.
--It would only be a very medically savvy person who'd know what they want in advance under some circumstances. Furthermore, situation and experience affect our preferences, so my decisions of one moment may change.
--Writing out one's preferences is likely to be either too specific to apply to what happens, or too general to fit the circumstances.
--Most living wills are written years before they become relevant, and are sometimes filed with attorneys who don't know when they are needed; more than half of those who have them don't give them to their doctors; admitting clerks don't find out they exist; their provisions are not recorded in charts—and people transferred from nursing homes are transferred without them.
--Even if they are written, clear and present, they have to be interpreted or specified to the situation, and strangers are often better at doing that than families.

They are supposed to have instrumental advantages that are also problematic. For one thing, they don't seem to have much effect on how people are treated. The willingness of physicians to withhold treatments is high for DNR—but very low for pain. Also, the phrasing of most such documents requires imminent dying, which is impossible to estimate. Also, people's own distress at the serious illness of others overwhelms their ability to advocate for the patient's wishes.

The hypothesized advantages are minimal. The conversations they prompt are typically superficial; they give people a false sense of security; and they are expensive. Health care power of attorneys have all the advantages of advance directives and few of the disadvantages. And while we are at it, we should repeal the Patient Self Determination Act, too.

State of Tennessee DHS v. Mary C. Northern (1978) + Transcript

SAL cite this as a *case* demonstrating 'the factual and conceptual difficulties involved in determining competency.' (p. 326) It falls in the grey area between clearly capable and clearly incapable.

This is an appellate court decision: that means it has to be decided on the basis of legal technicalities. The lower court has decided to declare her incompetent in order to allow the amputation of gangrenous feet. It has apparently been appealed in order to

challenge the vagueness of the Tennessee statute about what constitutes ‘imminent danger of death’ and ‘capacity to consent.’ The appeals court affirms that judgment—but does not take on the task of rendering those phrases less vague. [The court ordered the amputation, but it never took place, and MN died in the hospital.]

Dax’s Case as it Happened

This is an extremely widely discussed case.

Questions for discussion:

1. Do you agree with the court’s decision on the Mary Southern case? What values were prioritized in declaring her incompetent? Does the seriousness of the illness and the relative ease of the remedy for it affect your judgment? Does your opinion change when you imagine yourself in the subject-position of the doctor, or in the subject position of the judge?
2. Brock and Buchanan justify the importance given to capacity by its relation to the values of beneficence and autonomy. Which of the two do you consider most important in the Mary Southern case? In the Dax case?
3. Think about how you might answer the questions on pages 3 & 4 of the Advance Directive form from the state of California. Do you think you’d answer the questions the same way in 10 years? 20? 30?
4. The Dax case is one of the most discussed cases in bioethics. Would your opinion have been the same if you had read a two paragraph summary of the case? Food for thought: how much does the aesthetic effect of presentation affect our ethical judgments? Does it matter whose subject-position is taken in the summary of the case?