Assessing Decision-Making Capacity

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Physicians frequently are asked to assess whether a patient has the capacity to make informed decisions about his or her medical care. Such assessments may be difficult and controversial. There are few explicit legal standards for judging competency to make medical decisions. Furthermore, clinical practices for evaluating decision-making capacity are problematic. The following case illustrates some of these problems.

Mrs. C., a 74 year old widow with congestive heart failure, angina pectoris, and mild dementia, has been admitted to the hospital for shortness of breath and chest pain. In the past three years she has suffered two heart attacks. During the past two months, her symptoms have worsened despite several medications, including maximally tolerated doses of diltiazem, furosemide and enalapril. She now develops shortness of breath and chest pain when walking one block. Because there are no other medical treatments for her condition, her physician recommends angioplasty or bypass surgery in order to ameliorate her symptoms. Coronary angiography would be the first step, to see if angioplasty or surgery would be feasible.

Her dementia is mild. She has forgotten about several clinic appointments. She usually recognizes her primary care physician, but seldom knows the date or the name of the clinic. When she is hospitalized, her mental functioning gets worse. She has a nephew who lives in the same city and arranges for a woman to help her with shopping, cooking, and housecleaning. This woman seems to genuinely care for her. Mrs. C. can afford to pay for these services. She has no other relatives. She seems to enjoy watching television and sitting in the park. At clinic visits, she usually smiles when she sees her physician.

When asked about her wishes for further tests and treatment, Mrs. C. says that she wants to go home. After many discussions, the cardiology team convinces her to agree to an angiogram. But on the morning of the angiogram, she changes her mind, saying that she doesn’t want anyone to put a tube into her heart. Before developing dementia, she has never expressed her preferences concerning life-sustaining treatment. Her nephew will do what she wants because she has always been independent and stubborn.

Mrs. C. is generally averse to medical interventions. Last year, she refused mammography for cancer screening, even though she is at high risk because of a family history of breast cancer. She has also refused drug treatment for a very elevated cholesterol level of 318 mg/dL after diet modification was unsuccessful, even though reducing her cholesterol might reduce her risk of further heart attacks.

Because some physicians and nurses are concerned that she is not competent to refuse tests or treatment, a psychiatrist is asked to see the patient. On a mental status examination, she does not know the date, the name of the hospital, or the name of her nurse. She recalls only one of three objects and cannot do serial subtractions from twenty. She refuses to talk further with the psychiatrist, saying that she is not crazy.

This typical geriatrics case raises many issues about capacity to make decisions about medical care. Some caregivers believed it was inconsistent to question her capacity to refuse angiography, while not challenging her ability to consent to it or refuse other care. Some nurses feared that she agreed to angiography only to halt the stream of people trying to convince her to have it. Another issue was the appropriate role for psychiatrists in determining decision-making capacity.

The Significance of Competence and Capacity

Strictly speaking, competence is a legal category. Adults are presumed to be competent unless a court
determines that they are incompetent. However, in clinical practice, courts and legally appointed guardians are rarely involved in making decisions about medical care. Instead, health care professionals identify persons whose competency to make medical decisions is questionable and decide whether further evaluation of competency is warranted. Furthermore, physicians often make de facto determinations that a patient is incompetent and arrange for decisions to be made by surrogates. For instance, if a person is unconscious or severely demented, she clearly lacks the capacity to make decisions. When physicians determine that patients are incapacitated, standard medical practice is to ask the family members to act as surrogates. This clinical approach has been defended because routine judicial intervention would entail unacceptable delays and superficial reviews. In addition, in most cases family members are appropriate surrogates because they know the patient best and act in her best interests. The term incapacity is used to refer to assessments by physicians that patients lack the ability to make informed decisions about their health care. In this paper, we shall focus on such clinical assessments of decision-making capacity, as distinguished from determinations of competency by the courts.

Determining that a person is incapacitated is significant because her decision-making power may be taken away. The rationale for this practice is that patients who lack the capacity to make decisions should be protected from serious harm that might result from their decisions. Physicians have an ethical obligation to use their expertise for the benefit of patients. Such an obligation makes sense because physicians have special knowledge about harms which might result to such patients and are in a position to prevent such harms.

The obligation of physicians to protect patients from harm conflicts with their obligation to respect the autonomy of persons to make decisions that others might regard as foolish, unwise, or harmful. These two obligations can be reconciled when a patient lacks the capacity to make informed decisions. In this situation, it makes little sense to talk about patient autonomy. Interventions to protect such incapacitated patients thus do not violate the duty to respect patient autonomy.

In assessing decision-making capacity, physicians must balance protecting patients from harm with respecting their autonomy. A sliding scale has been suggested for such assessments: the more probable or serious the risk posed by the patient’s decision, the more stringent the standard of capacity that should be required. A sliding scale can be justified because it affords more protection to patients of questionable capacity when the potential harm resulting from their decisions is greater. Thus, it is appropriate to apply a more rigorous standard of capacity when Mrs. C. refuses treatment for symptomatic, life-threatening cardiac disease than when she refuses a screening test or treatment for risk factors.

But there are potential problems with such a sliding scale. Determinations of incapacity may be made inconsistently on different patients or by different physicians. A sliding scale might give too much weight to the views of physicians regarding the harms and benefits of medical treatment, rather than the views of patients. It might allow physicians to exercise control over patients who disagree with them.

Determining whether a patient is incapacitated is clinically significant only if medical decisions would change. Suppose the physician and surrogate agree with the patient’s choice, for example, Mrs. C.’s agreeing to angiography. There is little practical purpose in challenging the decision-making capacity of a patient when the physician believes that her decision is in her best interests. Even if the patient lacks the capacity to make decisions, the physician and surrogate would be ethically obligated to act in her best interests. The plan of care would be the same if the patient were regarded as capable. In contrast, when the physician disagrees with the patient’s decision, believing that it is not in her best interests, the course of care would change if the patient were regarded as having inadequate decision-making capacity. Thus it is appropriate that a disagreement between Mrs. C. and her physician triggers questions about her capacity to make medical decisions. Such disagreement, however, does not necessarily prove that the patient lacks such capacity.

Legal Standards for Competence

Even though competence is decided by the court, there are no clear legal standards for determining whether a person is competent to make medical decisions. A recent comprehensive legal treatise about life-sustaining treatment concludes that “the meanings of competence and incompetence are usually taken for granted or dealt with only in a cursory way by courts.” Often the ruling merely concludes or states that the patient is incompetent. There are several reasons for this lack of clear legal standards. In most landmark cases about life-sustaining treatment, the patient was unconscious or severely demented and thus clearly incompetent. Because findings of incompetence depend heavily on the facts of the particular case, it is
difficult to formulate general standards. Furthermore, usually the crucial issue before the court is whether treatment should be given, not whether the patient is competent.

The older cases conceived of incompetence in general or global terms. That is, incompetence was inferred from a person’s overall ability to function in life. Many different tasks might be assessed, such as obtaining food and housing or managing financial matters. Factors such as medical diagnosis, general mental functioning, and appearance might also be considered by the court. Sometimes criteria for incompetence were quite sweeping, such as the diagnosis of “senility.”

It is more appropriate to view incompetence in specific rather than general terms: a person should be considered competent or incompetent only with regard to a particular task. After all, a person may be capable of performing some tasks adequately, but not others. For instance, she may be able to make decisions about medical care but not about financial matters or vice versa. Meisel believes that a legal consensus is emerging that a person should be regarded as competent to make medical decisions if she is capable of giving informed consent. More specifically, a competent patient must appreciate his or her diagnosis and prognosis, the nature of the tests or treatments proposed, the alternatives, the risks and benefits of each, and the probable consequences. Meisel cautions, however, that courts have not explicitly adopted this approach, although it might be inferred from their rulings. In addition, the courts have not determined what level of understanding the patient must demonstrate to be regarded as competent.

Clinical Standards for Decision-Making Capacity

Like the courts, philosophers have suggested that it usually makes more sense to speak of capacity to make specific decisions about medical care than capacity in some general or global sense. Therefore decision-making capacity should be assessed by directly testing the patient’s ability to make a particular decision. The generally accepted standard is that the patient should have the ability to give informed consent (or refusal) to the proposed test or treatment. More specifically, a series of abilities is required:

1. The patient appreciates that she has a choice. That is, the patient must realize that she has decision-making power, not the physician or family members. Of course, one way for the patient to exercise that decision-making power is to ask the physician or relatives (to decide.) Unless the patient appreciates her power to make decisions, she may not play an active role when plans of care are discussed. In addition, the patient must be willing to exercise her decision-making power and make a choice among alternative courses of care.

2. The patient appreciates the medical situation and prognosis, the nature of the recommended care, the alternatives, the risks and benefits of each, and the likely consequences. In decisions about life-sustaining treatment, the patient should realize that declining treatment is an option and that such refusal may hasten her death. Philosophers have stressed that it is not enough to understand the issues in an intellectual way, for example that angioplasty or bypass surgery will probably relieve chest pain but that there is considerable perioperative mortality. In addition, the patient needs to apply this information to her own situation. In other words, Mrs. C. must realize that her chest pain and shortness of breath might be improved by angioplasty or surgery but that she might die because of surgery.

3. The patient’s decision should be stable over time and consistent with her values and goals. Some indecision is natural and understandable and does not call into question the ability to make decisions. Some persons, however, change their minds back and forth repeatedly without any changes in external circumstances, so that it is impossible to carry out plans for medical care. It is sensible to agree that such profound vacillation demonstrates that a person is incapable of making a decision, let alone an informed one. In addition, people may change their minds, particularly as their situation changes, as they receive more information or advice, or as they deliberate. Such changes, of course, should be respected. Thus Mrs. C.’s original agreement to angiography does not preclude her from later refusing.

It also seems appropriate to require that decisions be consistent with the patient’s own values and goals. Such consistency makes it more likely that the decision reflects the basic character and the values of the patient. This requirement therefore promotes patient autonomy, independence, and individuality. For example, if Mrs. C. wants to be at home, refusing surgery and the associated hospitalization and perioperative risk is consistent with that goal. But if she wants to be more active without pain, refusing surgery or angioplasty may not be consistent. Assessing whether a decision is consistent with values and goals may be difficult. Patients may not have well-articulated values and goals; instead, they may define their goals only through making a series of specific decisions about therapy. Furthermore, people may have multiple goals: Mrs. C. may want to be at home,
to be more active, and to be pain free. Because goals may conflict, a decision may be consistent with some objectives but not others. It may be that only by making a decision about surgery would Mrs. C. set priorities among these conflicting aims.

Some writers suggest that another element of capacity to make medical decisions is the ability to process information rationally. This requirement is controversial, depending on how “rational” is defined. One definition of rationality is consistency with the patient's own goals, values, and premises. As we have noted, such consistency seems appropriate. Similarly, it seems proper to require that decisions be “rational” in the sense that they are not based on delusions or hallucinations about the clinical situation. An example of such a delusion is the Northern case. Ms. Northern was an elderly woman who refused amputation of her gangrenous legs because she denied that gangrene had caused her feet to be “dead, black, shriveled, rotting and stinking.” Instead, she believed that they were merely blackened by soot or dust. The court declared her incompetent, because she was “incapable of recognizing facts which would be obvious to a person of normal perception.”18 The court said that if she had acknowledged that her legs were gangrenous but refused amputation because she preferred death to the loss of her feet, she would have been considered competent to refuse the surgery.

In contrast, other definitions of “rationality” would not be acceptable requirements for decision-making capacity. Rational may be interpreted to be what reasonable people would choose. Requiring rationality in this sense, however, would be too stringent, disqualifying decisions which are unconventional or highly personal. An example of a decision that does not meet this latter standard of rationality is refusal of blood transfusions by Jehovah's Witnesses. As one ruling declared, beliefs that others consider “unwise, foolish, or ridiculous”19 do not render a person incompetent. Indeed the right to give informed refusal would be meaningless unless such idiosyncratic decisions are respected, even though they conflict with accepted medical or popular wisdom.

Concerned that patients might be regarded as incapacitated merely because they make idiosyncratic decisions, some philosophers have recommended that assessments of decision-making capacity look only at the process by which the patient makes decisions, not at the content of the decision itself.20 Overlooking the decision itself, however, ignores the harm that it might cause the patient. While physicians have an obligation to respect unconventional choices, they also have an obligation to protect incapacitated patients from harm. As discussed previously, many writers suggest a sliding scale for assessing decision-making capacity. The greater the risk posed by the patient’s decision, the more exacting should be the standard of capacity that is applied.

### Assessing Capacity to Make Decisions

Physicians can do a great deal to enhance the decision-making capacity of elderly patients. Almost all elderly persons have some impairment in hearing, which may make it difficult to understand information presented by the physician. Because elderly patients may have difficulty with rapid speech, loud sounds, and back ground noises, it is helpful to speak slowly and distinctly and not to raise one's voice. The speaker should face the patient directly to provide visual clues. Furthermore, because some slowing of mental function is normal in the elderly, they may need more time to think about issues and to make a decision. If a patient is overwhelmed by too much information or pressured to make a decision quickly, she may become more confused.

Physicians should appreciate that decision-making capacity may change over time. As an illness progresses, patients may lose the capacity to make decisions. More importantly, the illness may have a fluctuating course. Impairments in decision-making capacity may be temporary or reversible. Patients with dementia typically worsen when they are hospitalized, particularly at night.21 Such deterioration may be caused by any concurrent medical illness, such as infection, dehydration, or electrolyte abnormalities. If possible, decisions should be deferred until such reversible conditions can be treated. Even after the acute medical problems are treated, the additional impairment of mental functioning may persist. Iatrogenesis is also common in elderly hospitalized patients. Medications given to treat anxiety, insomnia, pain, or hypertension commonly impair mental functioning.22 Elderly patients are more susceptible to side effects of drugs because they often receive many drugs which interact with each other and because drugs have a longer duration of half-life in the elderly. If there is concern that a particular medicine might be impairing the patient's capacity to make decisions, the interview should be repeated after the drug has been discontinued and its effect has worn off. Social factors, such as loneliness, depression, or unfamiliar hospital surroundings may also temporarily worsen dementia. It is helpful to bring in familiar items from home and have the hospital staff orient the patient repeatedly.

Physicians can also enhance patients’ decision-making capacity by addressing their reluctance to dis-
suss treatment. Some elderly patients may find it difficult to trust strangers and discuss life-sustaining treatment with them. Arranging for continuity of care by hospital personnel and for involvement of primary care physicians, family members, and friends in decision-making can be helpful.

Patients must express their choices and decision-making process in order for physicians to assess their decision-making capacity. Communication may be difficult for patients who cannot speak or write, as after a severe stroke. In such cases, caregivers may need to devise imaginative ways to communicate, such as asking questions that can be answered by nodding the head or spelling out words with an alphabet board. While such communication may be painstakingly slow, these patients would otherwise be excluded from decision-making.

People vary in their capacity to make decisions, and there is no natural cut point for how much capacity to make a medical decision is sufficient. Reasonable people may disagree over what operational criteria for decision-making capacity should be, how well a patient should be required to perform, and how certain observers should be that the patient meets the standards. Our impression is that standards required for performance and certainty may vary, depending on the risks associated with the patient's decision. There are sound reasons for adopting a sliding scale, with stricter requirements when the stakes for the patient are greater. It may be valuable, however, to define the requirements more explicitly.

More attention needs to be paid to standards of practice. Otherwise, determination of incapacity may be inconsistent. Different physicians might assess a patient's decision-making capacity differently. Alternatively, a physician might make different assessments of patients who did not differ in ethically relevant ways. Such inconsistency would be confusing, arbitrary, and unfair. Applebaum and Grisso give many helpful and practical suggestions for determining decision-making capacity. To check that disclosure of pertinent information has been adequate, the person evaluating the patient's decision-making capacity should ask the primary physician to repeat the discussion. To assess whether a patient has understood the disclosed information, the examiner should ask the patient to paraphrase it. "Can you tell me what the angiography is like?" "What would be the benefits of having angiography?" Patients should be asked to interpret probabilities of success and side effects in their own terms. To assess whether patients appreciate the situation and the consequences of their choices, the examiner can ask the patient what is likely to happen if she accepts or declines the treatment. Simple, open-ended questions can elicit whether the patient appreciates the consequences of her choices. For example, the examiner might ask, "What do you think will happen if you have angiography?" and "What do you think will happen if you do not have angiography?" It would also be appropriate to check that the patient appreciates that her symptoms might be relieved with angioplasty or surgery but that she might not survive the operation.

Decision-making capacity is obviously difficult to evaluate when patients like Mrs. C. refuse to answer questions or to explain their decisions. Paradoxically, repeated attempts to talk with the patient or convince her may be counterproductive. Patients may refuse to answer questions because they are annoyed at being in the hospital, angry at lack of control, or resentful at having so many people intrude on them. In turn, health care professionals may feel frustrated or angry. Often it is best to have a single person be the spokesperson for the health care team, rather than having many physicians and nurses trying to talk with the patient and persuade her.

The Role of Mental Status Testing and Psychiatric Evaluation

Clinicians often use mental status tests to assess whether a patient has the capacity to make medical decisions. Such tests assess a variety of mental functions. The level of consciousness, orientation of the subject to person, place, and time, attention span, immediate recall, short-term and long-term memory, and ability to perform simple calculations are tested with questions like those reported in the case description of Mrs. C. Language skills are tested by asking the patient to name objects like a watch and pen, to follow commands, and to repeat a sentence. Judgment and problem-solving abilities are assessed by asking the patient how to carry out a task such as getting a taxicab. The examiner also notes whether the subject appears depressed or has bizarre thoughts or delusions. More sophisticated neuropsychiatric tests assess abstract reasoning, disturbances of higher cognitive function, and spatial relationship.

The mental status test is useful to identify patients whose attention span and short-term memory are so impaired that they cannot keep in mind basic information about the proposed treatment. Such patients clearly cannot give informed consent and therefore lack the capacity to make informed decisions. But there are several problems with using mental status tests to assess decision-making capacity. There are no naturally defined "passing scores." Stan-
dards for scoring are statistically determined by comparing scores of persons judged for other reasons to have severely impaired mental status with scores of persons who are judged to be normal. In addition, scores on mental status tests may not be related to ability to make medical decisions. For example, Mrs. C. did not know the date or place and scored poorly on standard mental status tests. But if she understands that angiography or surgery would probably improve her chest pain and shortness of breath, she has the capacity to give an informed refusal.

Several court decisions have found that patients with abnormal mental status tests may be competent to make decisions about health care. Robert Quackenbush was a 72 year old man who withdrew his consent for amputation of his legs for gangrene. One psychiatrist felt Mr. Quackenbush had organic brain syndrome and psychosis, possible caused by his infection. This psychiatrist testified that the patient was disoriented to place and the people around him and had visual hallucinations. A second psychiatrist found that Mr. Quackenbush would lose his train of thought, but had no hallucinations. The latter psychiatrist said that Mr. Quackenbush knew he had gangrene and appreciated the severity of his illness. The probate judge, who spoke with the patient, found that “his conversation did wander occasionally but to no greater extent than would be expected of a 72-year-old man in his circumstances.” The patient hoped “for a miracle” but realized that “there is no great likelihood of its occurrence.” The court found Mr. Quackenbush competent to refuse surgery.

In a similar case, Lane v. Candura, a 77 year old widow was judged competent to refuse amputation of her leg for gangrene. Testimony indicated that Mrs. Candura was “lucid on some matters and confused on others,” that her “train of thought sometimes wanders,” and that “her conception of time is distorted.” One psychiatrist opined that she was incompetent, partly because her refusal to discuss the problem with him indicated that “she was unable to face up to the problem.” The court found that she understood that her refusal would most likely “lead shortly to her death” and characterized her refusal as “a choice with full appreciation of the consequences.” The court ruled that Mrs. Candura was competent. It found no evidence that her “forgetfulness and confusion cause, or relate in any way to, impairment of her ability to understand that in rejecting the amputation she is, in effect, choosing death over life.”

Psychiatrists often are asked to evaluate patients whose decision-making capacity is questionable. There are many sound reasons for this practice. Psychiatrists, who are skilled at interviewing patients with mental impairment, can ascertain a patient’s ability to understand the proposed treatment. In addition, psychiatrists are specialists in diagnosing and treating mental illness that might impair a patient’s decision-making capacity. For example, they might suggest that a patient who refuses treatment is depressed and might benefit from therapy or antidepressants. Similarly, psychiatrists can determine whether a patient’s refusal results from a delusional system and suggest whether antipsychotic medications might treat the delusions. Psychiatrists are also skilled at helping to resolve inter-personal and intrapsychic conflicts. A patient may be angry over loss of control in the hospital or over disagreements with physicians or nurses. Through empathetic discussions and nonjudgmental counseling, the psychiatrist often can minimize the impact of such feelings on decision-making.

However, there are also potential pitfalls in asking psychiatrists to determine whether patients lack decision-making capacity. Perl and Shelp warn that moral dilemmas may be masked during psychiatric consultations as scientific determinations of competency. But assessments of decision-making are not objective determinations about which all experts will agree. As the Quackenbush and Candura cases demonstrate, psychiatrists may disagree when evaluating a patient’s capacity to make decisions about medical care. The assessment may be influenced by the psychiatrist’s personal beliefs regarding how much protection should be given to persons of questionable competence. By focusing on mental status tests and the psychiatric interview, the psychiatrist may overlook fundamental ethical issues. Because the crucial ethical issue is whether the patient understands the nature of the treatment, the risks and benefits, the alternatives, and the consequences, it is essential to ask the patient about these issues directly, as well as testing mental function.

Another ethical issue that may be masked as a scientific decision is whether psychiatric illness renders the patient incapable of making informed decisions. To be sure, psychiatrists are expert at diagnosing mental illness and recommending treatment. But the ethical issues are quite different. For example, if a psychiatrist suggests that a patient who refuses treatment may be depressed, the ethical question is whether depression makes her refusal uninformed. Not every depressed patient has impaired decision-making capacity. Nor should every depressed patient who refuses medical treatment be treated with antidepressants, or have her refusal overridden. Indeed if a patient understands that the physician believes that she might change her mind if her depression were to be treated, she probably should be considered competent to refuse treatment for depression.
Disagreements between Physicians and Patients

Patients may refuse treatments even though physicians believe the benefits far outweigh the risks. When this occurs, physicians should keep in mind their duty of beneficence, to act in the best interests of their patients. Further efforts are appropriate to assess whether the patient is truly informed and has the capacity to make decisions. The amount of effort by physicians should be proportional to the likely consequences of the patient’s refusal. The greater the potential harm to the patient resulting from the refusal, the greater the duty on physicians to probe for misunderstandings or lack of capacity. But physicians should do more than consider whether there is something wrong with the patient. They also should ask what might be wrong with doctor-patient communication or with the doctor-patient relationship.

When a patient refuses recommended treatments, health care workers should consider whether sufficient options are being offered to the patient. In the case of Mrs. C., the option of going home and discussing angioplasty and surgery at an outpatient visit was not considered. Rather than insisting that a decision be made that day, it might be better to acknowledge that the choices are difficult and to allow the patient more time to deliberate. The physician might say to Mrs. C., “It must be very hard to make this decision.” Pressuring patients to decide may make it more difficult for them to make informed choices. Paradoxically, if patients feel that they have control over the decision-making process, over the pace andsettling of decision-making, they may be more willing to make a choice. The physician might say, “Many people find it easier to make such a decision if they go home and think about it. Would you like to do that?”

Commentators have suggested that physicians should try to negotiate a mutually acceptable plan of care with the patient.35 Negotiation implies that both parties have approximately equal power and that neither side should expect the other to accept its position. Negotiating is not equivalent to trying to get the patient to cooperate with the doctor. An essential step in negotiating is eliciting the patient’s perspective and concerns. With Mrs. C., it would be important to ask, “What concerns you most about angioplasty or surgery?” If the patient feels that her point of view has been understood, she is in turn more likely to listen to the physician’s perspective and to make a choice. In addition, misunderstandings can be corrected. For example, the patient might mistakenly believe that angioplasty requires a lengthy hospitalization. Thus the physician’s skill at listening to and talking with patients may have a great impact on whether the patient seems capable of making an informed choice. As the Quackenbush and Candura cases illustrate, good interviewing skills and respect for the patient’s viewpoint can help make decisions more informed and the patient’s decision process more understandable. While this process of listening and negotiating may take a good deal of time, the alternative may be to spend even more time and effort when patients refuse care which the doctors recommend.

Even if the patient’s capacity to make decisions is questionable, it may be useful to negotiate a mutually acceptable plan of care with the patient. It is impractical as well as morally uncomfortable to impose treatment on an unwilling patient. Patients may balk at blood draws or x-rays. In addition, patients may shout or scream their refusal. Even if such a patient were declared incompetent by the courts, it would still be difficult to carry out treatment. It is preferable if the patient assents to treatment, even if she cannot give truly informed consent. Persuasion, education, and asking family members and friends to talk to the patient would be acceptable to try to gain the patient’s assent and cooperation. Often a patient will agree to treatment after caregivers have listened to her feelings and objections, modified the treatment plans, or changed the hospital routine.

Making Decisions for Incapacitated Patients

This article has focused on determining whether a patient has the capacity to make decisions about medical care. A related question is also important: How should decisions be made when patients lack such capacity? Until recently, there was a legal and ethical consensus that families could make decisions on behalf of incompetent patients, provided that those decisions followed the patient’s previous directives or best interests.36 In practice, families and physicians usually make joint decisions, without resorting to the courts. But such joint decisions have been called into question by two recent court decisions.37 In the O’Connor case, involving a 77 year old woman with multi-infarct dementia, the highest court in New York State ruled that an incompetent patient must be given life sustaining treatment unless there is “unequivocal” or “clear and convincing” evidence that she would refuse it.38 The O’Connor court refused to accept the kinds of prior patient statements that other state supreme courts have deemed clear and convincing. In the Cruzan case, the Missouri Supreme Court ruled that tube feedings could not be withdrawn from a 31 year old woman who was in a persistent vegetative state.39 The Court declared that the state had an
“unqualified” interest in prolonging life. In each case there was considerable evidence that the patient would not want treatment continued. Both rulings rejected decisions by family members based on the incompetent patient's best interests, even though both families were acknowledged to have the purest motives. The U.S. Supreme Court has heard an appeal on the Cruzan case and has issued a ruling on life-sustaining treatments for the first time, upholding the Missouri Supreme Court.

If the reasoning of the O'Connor and Cruzan decisions is adopted more widely, many incompetent patients might be subjected to treatments that they and their families do not want. In these two cases there was no question that the patients were incompetent. But for patients whose capacity to make decisions is questionable, such as Mrs. C., determinations of incapacity may become crucial. As previously discussed, physicians might set high standards for decision-making when they believe that a patient is refusing highly beneficial treatment. By regarding her as incapacitated, they could carry out the recommended treatment despite her objections. Conversely, physicians might set low standards for decision-making when they believe that a patient is refusing treatment that is not in her best interests. By regarding such a patient as capable of making decisions, physicians could withhold the treatments in accordance with her "informed" refusal. In contrast, if such a patient were considered incapacitated, the reasoning of the Cruzan and O'Connor cases would require treatment to be given. But adjusting the standards for decision-making capacity in order to achieve certain decision outcomes would be arbitrary and unfair and cause cynicism about the decision-making process.

As a result of the O'Connor and Cruzan rulings, the procedural question of whether a patient is incompetent might be substituted for the question of what treatment is appropriate. Because Americans have been unable to reach agreement on some substantive issues regarding life-sustaining treatment, debate has shifted to procedural rules, such as what kind of advance directives are required. But transposing disagreements over life-sustaining treatment into procedural debates over assessing competence may provide only illusory resolution. Assessing decision-making capacity in this manner might be biased and confounded by other issues. It would be more honest to confront substantive disagreements over the appropriateness of treatment.

In summary, the decision-making capacity of elderly patients may be questionable. Physicians play an important role in assessing capacity and arranging for surrogate decision-making for incapacitated patients. Because physicians have such power, it is important that they understand the concept of decision-making capacity and establish clear standards for evaluating individual patients.

References


3. Id., Buchanan; Id., Meisel; Id., President's Commission, Making Health Care Decisions.

4. President's Commission, note 2 supra, Making Health Care Decisions, Deciding to Forego Life-Sustaining Treatment.


7. Appelbaum et al., supra note 1.


10. Appelbaum, supra note 1; Meisel, supra note 1.

11. Meisel, supra note 1.

12. Ibid.

13. Ibid.

14. Ibid.


16. Appelbaum, supra note 1; Buchanan, supra note 1.


25. Ibid.
27. Ibid.
29. Ibid.
31. Id., Perl.
32. Ibid.
33. Lane v. Candura, supra note 28.
38. Id., In re O'Connor.